DOCUMENT RESUME

ED 216 295 CG 015 979

TITLE	Physical and Financial Abuse of the Elderly. Hearing before the Subcommittee on Retirement Income and Employment of the Select Committee on Aging. House of Representatives, Ninety-Seventh Congress, First Session (San Francisco, Calif.)
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-97-297
PUB DATE	3 Apr 81
NOTE	273p.; Paper copy not available due to small print size.
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	*Aggression; *Family Problems; Family Relationship; *Financial Problems; Gerontology; Government Role; Hearings; Individual Characteristics; *Older Adults; Psychological Needs; Social Problems; Victims of Crime; *Violence
IDENTIFIERS	*Congress 97th; *Elder Abuse

ABSTRACT

The proceedings of this subcommittee of the House of Representatives Select Committee on Aging explore the incidence and causes of elder abuse and consider ways of dealing with the problem. Statements of victims of elder abuse and statements of social service personnel are included. Legal aspects of the problem and the possibility of government intervention are explored. The appendices contain further information and research from various states, historical and questionnaire data on protective services for the elderly, and information on physical, emotional, and financial abuse of elderly persons. (JAC)

****
*   Reproductions supplied by EDRS are the best that can be made   *
*   from the original document.   *
****

HARD COPY NOT AVAILABLE

PHYSICAL AND FINANCIAL ABUSE OF THE ELDERLY

ED216295

HEARING

BEFORE THE

SUBCOMMITTEE ON RETIREMENT INCOME
AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

FIRST SESSION

APRIL 3, 1981, SAN FRANCISCO, CALIF.

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 97-297

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

CG 015979

79-490 O

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1981

SELECT COMMITTEE ON AGING

CLAUDE PEPPER, Florida, *Chairman*

EDWARD R. ROYBAL, California
MARIO BIAGGI, New York
IKE ANDREWS, North Carolina
JOHN L. BURTON, California
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD BOUQUARD, Tennessee
JIM SANTINI, Nevada
DAVID W. EVANS, Indiana
STANLEY N. LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
GERALDINE A. FERRARO, New York
BEVERLY B. BYRON, Maryland
WILLIAM R. RATCHFORD, Connecticut
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
EUGENE V. ATKINSON, Pennsylvania
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
BOB SHAMANSKY, Ohio
RON WYDEN, Oregon
DONALD JOSEPH ALBOSTA, Michigan
GEO. W. CROCKETT, Jr., Michigan
WILLIAM HILL BONER, Tennessee

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
WILLIAM C. WAMPLER, Virginia
JOHN PAUL HAMMERSCHMIDT, Arkansas
MARC L. MARKS, Pennsylvania
RALPH REGULA, Ohio
ROBERT K. DORNAN, California
HAROLD C. HOLLENBECK, New Jersey
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
DAN LUNGREN, California
MILLICENT FENWICK, New Jersey
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
THOMAS E. PETRI, Wisconsin
JUDD GREGG, New Hampshire
DAN COATS, Indiana
GEORGE C. WORTLEY, New York
HAL DAUB, Nebraska
LARRY E. CRAIG, Idaho
PAT ROBERTS, Kansas
BILL HENDON, North Carolina
GREGORY W. CARMAN, New York

CHARLES H. EDWARDS III, *Chief of Staff*
YOSEF J. RIEMER, *Deputy Chief of Staff*
VAL J. HALAMANDARIS, *Senior Counsel*
JAMES A. BRENNAN, *Assistant to the Chairman*
WALTER A. GUNTHARP, Ph. D., *Minority Staff Director*

SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

JOHN L. BURTON, California, *Chairman*

THOMAS J. DOWNEY, New York
DAVID W. EVANS, Indiana
MARY ROSE OAKAR, Ohio
GERALDINE A. FERRARO, New York
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BARNEY FRANK, Massachusetts
BRUCE F. VENTO, Minnesota
TOM LANTOS, California
RON WYDEN, Oregon

WILLIAM C. WAMPLER, Virginia,
Ranking Minority Member
HAROLD C. HOLLENBECK, New Jersey
NORMAN D. SHUMWAY, California
JAMES M. JEFFORDS, Vermont
JUDD GREGG, New Hampshire
DAN COATS, Indiana
BILL HENDON, North Carolina
GREGORY W. CARMAN, New York

MERRILL S. RANDOL, *Majority Staff Director and Counsel*
NANCY E. HOBBS, *Minority Staff Director*

CONTENTS

MEMBERS OPENING STATEMENTS

Page
Chairman John L. Burton 1
Mary Rose Oakar 6
Tom Lantos 8

CHRONOLOGICAL LIST OF WITNESSES

Gerald N. Felando, chairman, California State Assembly Committee on Aging 11
Mrs. X, statement made by Leigh Hubert, program director, Native American Seniors Center, San Francisco, Calif 14
Mrs. B., read into the record by Lucy Fitzpatrick, legal worker, Senior Adults Legal Assistance, San Jose, Calif 15
James C. Bridgewater, nursing home resident 16
Mrs. D., statement read into record by Charlotte Humphrey, director, Area Agency on Aging, Sacramento, Calif 18
Chuck Paussa, Citizens for Better Nursing Home Care, Oakland, Calif 19
Ephraim Lugo, social worker, Department of Social Services, San Jose, Calif 20
George Alexander, dean, Santa Clara Law School, Santa Clara, Calif 29
Alfred Chiplin, Jr., National Senior Citizens Law Center, Los Angeles, Calif 31
Mike Gilfix, director, Senior Adults Legal Assistance, Palo Alto, Calif 36
Bruce A. Feder, managing attorney, Legal Assistance to the Elderly, Inc., San Francisco, Calif 42
Edwin Villmoare, executive director, National Paralegal Institute, San Francisco, Calif 49
Margaret O'Rourke, director of planning, Legal Research and Services for the Elderly, Boston, Mass 51

APPENDIXES

Appendix 1. "Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers," submitted for the record by Edwin Villmoare 57
Appendix 2. Additional material received for the record:
  "Elderly Abuse by Adult Caretakers: An Exploratory Study," a joint statement submitted by Linda S. Boydston and James A. McNairn 135
  Don Jacobson, chief assistant district attorney, San Francisco, Calif 136
  Cecilia London, M.S.W., program director, Marin Senior Day Services, Mill Valley, Calif., letter and attachment 137
  Rev. Edward L. Peet, president, California Legislative Council for Older Americans, San Francisco, Calif., prepared statement 139
  Maureen Satz, study director for research on elder abuse, UCLA/USC Long Term Care Gerontology Center, prepared statement and attachment, entitled "Mandatory Reporting Legislation for Adult Abuse" 139
  Anonymous statement No. 1 164
  Anonymous statement No. 2 168
Appendix 3. Summary of "Elder Abuse: An Examination of a Hidden Problem," a report by the U.S. House Select Committee on Aging, submitted for the Record by Chairman John L. Burton 169

PHYSICAL AND FINANCIAL ABUSE OF THE ELDERLY

FRIDAY, APRIL 3, 1981

U.S. House of Representatives,
Select Committee on Aging,
Subcommittee on Retirement Income and Employment,
San Francisco, Calif.

The subcommittee met, pursuant to notice, at 10 a.m., in the Crystal Ballroom, San Franciscan Hotel, Hon. John L. Burton (chairman of the subcommittee) presiding.

Members present: Representatives John L. Burton, Oakar, and Lantos.

Also present: Assemblymen Felando and Filante of the State of California Assembly.

Staff present: Merrill S. Randol, staff director and counsel, Subcommittee on Retirement Income and Employment. Val Halamandaris, senior counsel, and Kathleen Gardner, professional staff, of the Select Committee on Aging.

OPENING STATEMENT OF CHAIRMAN JOHN L. BURTON

Chairman Burton. The Subcommittee on Retirement Income and Employment of the House Select Committee on Aging will come to order.

It is a pleasure to hold this hearing and to welcome you to San Francisco.

The subject of our hearing today is the physical and financial abuse of older Americans by their relatives and by their caretakers.

We are particularly fortunate that our hearing coincides with the first National Conference on Elder Abuse, a gathering which includes some of the foremost experts on domestic violence.

We look forward to hearing from our witnesses this morning and to include some of their recommendations of the National Conference in our hearing record. We are also pleased to include in the appendix of our hearing record an excellent manual on elder abuse, "Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers." This manual was prepared for the Oregon Office of Elder Affairs by the National Paralegal Institute.

We have chosen this time and place to release the Committee's report of the first national investigation on the issue of elder abuse. This report, entitled "Elder Abuse: An Examination of a Hidden Problem," is the result of more than a year's work. A summary of this report will be included in the appendix of today's hearing record. The executive summary follows:

5

EXECUTIVE SUMMARY

The current roadblock to understanding the nature and incidence of family violence, in general, and elder abuse, in particular, is that the topic is so emotionally charged. Many would prefer not to acknowledge that such abuse exists—it is alien to the American ideal. Even abused elderly are reluctant to admit their children, loved ones, and those entrusted with their care have assaulted them. For this reason, the abuse of our elderly at the hands of their children until recent times has remained a shameful and hidden problem.

This report was an attempt to explore what is known about elder abuse. How much is there in America? Is it increasing? What causes children and caregivers to abuse their parents and wards? And, can we prevent it?

To answer these questions, the Committee undertook the following steps:

—Collected, reviewed and tabulated letters and case histories received by the Committee over the past five years as well as letters received by Congressional offices.

—Reviewed all State studies including those prepared by experts in academic settings, and interviewed these experts.

—Interviewed experts with the U.S. General Accounting Office who are involved in an investigation of one aspect of financial abuse of the elderly by their relatives and/or caretakers.

—Reviewed indictments, Grand Jury presentments and other public Court records in several States.

—Prepared and sent a questionnaire to all State Human Service Departments at the Chairman's request. The responses to these questions were tabulated and appear in Section IV of this report. The questionnaire can be found in Appendix I.

—Conducted follow-up telephone interviews with over one-third of the State Human Service Departments. A Directory of Offices responsible for Adult Protective Services appears in Appendix VII.

—Reviewed all books, periodicals, and newspaper references relating to elder abuse and family violence in the possession of the Library of Congress.

—Reviewed all hearings and reports on abuse of the elderly by Congressional Committees and administrative agencies.

—Prepared and sent a questionnaire to police chiefs of major metropolitan cities across the United States at the Chairman's request. The responses to these questions were tabulated and appear in Section II of this report. The questionnaire can be found in Appendix V.

—Prepared and sent a questionnaire to staff of Visiting Nurses Association in the District of Columbia, Maryland, and New Jersey. The answers to these questionnaires were tabulated and appear in Section II of this report. The questionnaire can be found in Appendix VI.

—Reviewed and summarized case histories of abuse forwarded to the Committee by the States, the police chiefs, visiting nurses, and abused elderly. These case histories can be found in Section I of this report.

—Prepared and sent a letter, under the signature of the Chairman, to a number of notable and respected authorities on elder abuse to ascertain their views with respect to the nature and extent of such abuse.

—Communicated with numerous organizations and service providers representing the elderly to ascertain their views on the problem of elder abuse.

—Contacted the Emergency Nurses Association to determine their experience with elder abuse.

—Held hearings in Massachusetts, New York, New Jersey and Washington, D.C. for the purpose of gathering information on the issue of elder abuse, including a joint hearing with the Senate Committee on Aging.

This report, which culminates more than a year of work for the House Select Committee on Aging, is the first full-scale national investigation of the subject of elder abuse ever undertaken. As such, it is not and cannot be the final and definitive study in this area. The Committee found that many States had no data with which to answer its questionnaires. It is fair to say that all of the States now realize that the problem of elder abuse exists in sizeable proportions and that they need to take steps to deal with it. It is also fair to say that, with the exception of a few States, most local jurisdictions do not have effective programs underway at present and that there are tremendous gaps in State legislation as it relates to the protection of the aged from abuse.

Notwithstanding the limitations on data from the States, the Committee was able to reach a number of conclusions which were supportable beyond doubt. They were as follows:

—The Committee found that elder abuse is far from an isolated and localized problem involving a few frail elderly and their pathological offspring. The problem is a full-scale national problem which exists with a frequency that few have dared to imagine. In fact, abuse of the elderly by their loved ones and caretakers exists with a frequency and rate only slightly less than child abuse. There is no question but that the problem is increasing dramatically from year to year.

—The Committee learned that abuse of the elderly is far less likely to be rereported than the abuse of children. While one out of three child abuse cases is reported, only one out of six cases of adult abuse come to the attention of authorities.

—The Committee concluded that some 4 percent of the nation's elderly may be victims of some sort of abuse from moderate to severe. In other words, one out of every 25 older Americans, or roughly one million older Americans may be victims of such abuse each year.

Section I of this report provides hundreds of examples of elder abuse from virtually every part of the United States. These recent examples range from what may seem a trivial theft of the social security check of the elderly by their relatives all the way to murder, mayhem, assault, fraud, larcency and rape. It should be pointed out that the expropriation of a social security check has almost the same devastating consequences for the elderly. It deprives them of their livelihood, of their identity and their sense of security. It may put them at the complete mercy of those who wish to control their every action. The theft of the income of the elderly along with occasional use of violence are two tools with which some family members carry out a reign of terror against their seniors:

—Physical violence including negligence is the most common form of abuse, followed by financial abuse, the abrogation of basic constitutional rights and psychological abuse. However, there are numerous examples in the Committee files in which all four of these abuses are perpetrated simultaneously. In most cases, the abuse was active and involved acts of omission by children who are placed in a caretaking role although there are numerous examples of passive abuse or negligence which have come to the Committee's attention.

—Most instances of elder abuse are recurring events rather than single incidents. Cases are included in Section I which involve the aged who have been physically or financially abused over a 10-year period or more.

From the hundreds of cases included in Section I and from similar examples in the Committee's files, it is possible to draw a profile of the most likely victims of elder abuse and those most likely to perpetrate it:

—The victims are likely to be very old, age 75 or older. Women are more likely to be abused than men. The victims are generally in a position of dependency—that is, they are relying on others (and generally on those who abuse them) for care and protection.

As to why they do not report cases of abuse, it appears that the elderly who are abused are often ashamed or may not want to bring trouble to their children or they may fear reprisals if they complain. Some seniors do not have the physical ability or sometimes have been deprived of the opportunity to register complaints by one means or another even if they wished to do so. Even with the limited resources at their disposal, the States have confirmed that at least 50 percent of the complaints about elder abuse are substantiated, while 30 percent were not and the remainder were inconclusive. This suggests that complaints of a frivolous nature are not a common phenomenon:

—The likely abuser will undoubtedly be experiencing great stress. Alcoholism, drug addiction, marital problems and long-term financial difficulties all play a part in bringing a person to abuse his or her parents. The son of the victim is the most likely abuser accounting for about 21 percent of all instances, followed by the daughter of the victim in about 17 percent of all cases. Third in line was the spouse of the victim when acting in a caregiving role, with the male spouse slightly more likely to be the abuser than the abused. It is also interesting to note that those who were abused by their parents as children are more likely to abuse their aged parents.

Section II of this report provides the reader with at least 14 different categories of support for the Committee's conclusion that elder abuse is a widespread, serious and growing problem. The Committee's hearings, of course, are a prime source of support for the conclusions which are stated in this report. The hundreds of letters and cases received by Members of Congress and referred to the Committee on Aging are another source. The Committee's questionnaires to 30 police chiefs, to home health agencies and to State Protection Service Departments add reinforcement, as do newspaper exposes and numerous studies by universities. The testimony and hearings before the State legislative committees, Grand Jury investigations and investigations by the U.S. Postal Service all help to create the picture of a desperate problem which can no longer be ignored.

As noted in Section III, no one theory provides the entire explanation for the cause of elder abuse. Any one or a combination of any of the following factors may explain why our elders are abused: the abuser may lack community resources to assist them in their caregiving role; the abuser may have been abused as a child and returns to abuse the parent; the abuser may be suffering from psychological, alcoholic or drug-related problems; the abuser may resent caring for a dependent relative or may be frustrated in their inability to assume the additional financial responsibilities which accompany such care; the abuser may accept violence as a way of life or lack close family ties—the love and friendship accumulated over time which are necessary to counteract the hardships in caring for a dependent family member; or the abuser may be experiencing some major stress-producing event which triggers abusive behavior. On the other hand, the abused may be too demanding or simply ungrateful and thus initiate abusive situations.

Section IV describes data received from the States and supports the following conclusions:

—Numerically, there are three times as many child abuse cases as adult abuse cases. Therefore, it should seem that one-third of the State's budgets should be devoted to adult protective services. However, the States are spending the great bulk of their limited funds to combat child abuse. On the average, they commit only 6.6 percent of their protective service budgets to the elderly, with 86.7 percent going to children, and the remainder being spent on adults age 18 to 64.

—Twenty-six States have what they consider to be adult protective service laws, which vary widely in scope. Only 16 of the States with adult protective service laws also require the mandatory reporting of elderly abuse cases. There is, however, little consistency among these States as to whom is required to report and what penalties will apply when there is a failure to do so. Of the States without adult protective services laws or mandatory reporting provisions, 20 have sponsored bills in their State legislatures. Only 10 States do not have adult protective service laws, mandatory reporting provisions, or legislation pending consideration.

—The majority of States agreed that their statutes relating to adult protective services are ineffective and the needs of the abused elderly are currently not being met through these existing laws.

—The overwhelming majority of the States reported that they would favor legislation to establish model mandatory reporting requirements for elder abuse to be adopted by the States.

—The overwhelming majority of the States support the passage of legislation which would provide incentives to the States to develop adult protective service programs with mandatory reporting provisions, as incorporated in H.R. 769.

Section VIII includes a number of policy options for consideration of the Congress and States:

—The Congress may wish to enact H.R. 769, the Prevention, Identification and Treatment of Elder Abuse Act of 1981. This bill would provide for the financial assistance for programs of prevention, identification, and treatment of elder abuse, neglect and exploitation, and establish a National Center for Adult Abuse. The bill would provide Federal funds to States which had mandatory reporting laws and provided for immunity from prosecution for persons reporting incidences of abuse, neglect and exploitation. Additionally, States should have trained personnel and services available to abused, neglected and exploited elders.

—Congress may wish to amend Title XX, Medicare, Medicaid and SSI to provide for more social services to families who are caring for an older person, such as respite care, home health services, personal services, homemaker services, home-delivered meals, and adult day care.

—The States may wish to consider enacting legislation incorporating the provisions included in H.R. 769, the proposed "Prevention, Identification and Treatment of Elder Abuse Act of 1981," as introduced in the U.S. Congress.

—Additional recommendations can be found at the end of this report.

[See appendix 3, p. 169 for summary of report.]

We have found that elder abuse is truly a national tragedy. Up to 1 million older Americans are being victimized every year. Although such abuse is often associated with nursing homes and institutions, our report leaves little doubt that there may be much more abuse taking place in private homes at the hands of the elderly's relatives than in any of the institutions.

It is also clear that little has been done to address this serious problem. Legislatures and Congress have tried to deal with the problem of domestic violence and child abuse, but the hidden problem, as we call it, has not been addressed, partly because it is a hidden problem. We hope that these hearings and the report will make it a problem that is right up front in the matter of concern to all of our colleagues.

The fact that only 1 in 6 cases is reported to authorities is the reason that it is a hidden problem. The States spend only 6 percent of their protective services money on the elderly. Only 26 States have any form of protective services laws, and only 16 of those State laws include the essential mandatory reporting provisions; 10 do not.

There is legislation pending here in our State to upgrade our protective services. And I am sure that that will get good reception, good action in the State legislature, having served up there. Also knowing the leadership, they are approaching the status of the elderly, themselves, and pretty soon they may be interested in the issue more than years ago.

It seems to me that at the Federal level we can accomplish a great deal by providing small amounts of grants, and to get President Reagan's support, we will call them block grants, to help the States upgrade their protective services programs.

The current mood in Washington, and throughout the country, is not to get involved in new programs and save money. And we all agree with saving money. Many of us feel that saving the mental health and the physical health and the lives of the elderly should be weighed against the saving of money.

I, for one, find that the saving of a person's life and dignity do outweigh the money if efficiently and prudently spent.

We owe a debt to our forebearers, the elderly of this Nation, which can really never be repaid. They suffered through the depression. They suffered through World War II. Many of them fought in it. They suffered through problems that those of us who still consider ourselves young did not have to face. And it would be an immoral act on the part of our Government to enjoy the fruits of their labors and deny them their basic rights.

The elderly, in my judgment, have been among the most shortchanged in our society, if you weigh it on equity or if you weigh it just on what they have done for this Nation in return for what they have received from this Nation.

And, it is the test of the society how we treat those less fortunate than ourselves and how we provide for people in the autumn of their lives. We believe this hearing in bringing out this hidden problem might be able to lead the way to some legislation this year and, hopefully, some money, if not within this fiscal year, within the next year.

I do believe that we have to get legislation on the books and if the funding cannot come this year, we will have it come next year, but we must take this step to do it and do it now. And I think that we will probably find a little bit of money invested will probably reap not only a moral return but a financial return to our Nation's Treasury.

At this time, I would like to introduce my distinguished colleague, Ms. Mary Rose Oakar from Cleveland, Ohio.

Mary Rose.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. Oakar. Thank you, Mr. Chairman.

I am very, very pleased to be here today in your beautiful city of San Francisco, joined by our colleague, Mr. Lantos, I appreciate your having this hearing. I think that it is important that our subcommittee and our committee get into areas of the country to see, at the grassroots level, the dimensions of this problem.

I have a prepared statement that I wish to submit to you for your record, Mr. Chairman.

I just want to say I was heartened that our report recommended, and the State agencies agreed that we need some Federal mandate in order to deal with this problem. That is why I introduced a bill related to elder abuse and prevention. I was joined by yourself and Congressman Pepper as sponsors so we can provide for a national center on elder abuse and we can have mandatory reporting and immunity from prosecution, which I think is the key area.

We can provide for the kinds of services that those who do the abusing need very often in order to remove some of their stress.

Finally, I would like to say that it is interesting that in 1874, the first public awareness of child abuse came in a case of an 8-year-old abused girl. She was represented by the American Society for the Prevention of Cruelty to Animals. They represented her in showing that this child was abused. Finally, there was some protection provided by the courts in New York City.

It was not until 100 years later that Congress passed the Child Abuse Prevention and Treatment Act, which is so important to assist States in dealing with this very traumatic and difficult problem.

In 1979, our committee finally had some hearings on this issue. And then, ultimately, we introduced the elder abuse bill. We are hoping that it does not take us 100 years to deal with this problem of elder abuse which is a phenomenon that is affecting more than 1 million older Americans each year. And those are just the ones that we can document.

I am really very grateful for the witnesses who have the courage to be here too, particularly, those who have been abused.

Thank you very much, Mr. Chairman, for your leadership and for having us here.

[The prepared statement of Representative Mary Rose Oakar follows:]

PREPARED STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Mr. Chairman, thank you for holding this important hearing today on physical and financial abuse of the elderly. This is the sixth hearing of the Select Committee on Aging during the past two years dealing with abuse of our older Americans and we are sadly aware that we have only discovered the tip of the iceberg when we discuss the serious national scandal of elder abuse. I am pleased that our Subcommittee on Retirement Income and Employment is holding this hearing today to hear testimony from unfortunate victims of financial and physical abuse. Additionally, we will hear from the service providers and legal counselors who have helped these victims through their horrendous ordeals and from members of your California State Assembly who are knowledgeable about the problem of elder abuse.

I think it is most appropriate that our Subcommittee on Retirement Income and Employment holds this hearing as part of the two national conferences on elder abuse which have been funded by the Administration on Aging and jointly sponsored by the National Paralegal Institute and the Legal Research and Services for the Elderly. Additionally, I am pleased that today our esteemed Chairman of our Select Committee on Aging, Senator Claude Pepper, has released the results of the year-long staff investigation of the hidden problem of elder abuse. I have read this report and I am deeply saddened and disheartened by the harsh realities of elder abuse uncovered by this investigation. However, at the same time, I am heartened by the fact that this report will provide a factual basis for educating American citizens and lawmakers about the serious extent and impact of this national problem which affects an estimated one million older Americans each year.

I am also heartened by the recommendations of this report which include the suggestion that Congressional action be taken to pass H.R. 769, the Elder Abuse Prevention and Treatment Act which I authored and introduced with Chairman Claude Pepper. This bill proposes to establish a National Center on Elder Abuse and to provide Federal funds to States for elder abuse prevention and treatment programs. In order to qualify for these funds, States must have in effect an elder abuse, neglect, and exploitation law which provides for mandatory reporting and immunity from prosecution for persons who report suspected instances of elder abuse, neglect, and exploitation. Additionally, States must investigate suspected cases of elder abuse, neglect, and exploitation, and must have trained personnel and services available to help abused older Americans.

Results of the Committee Report on Elder Abuse released today indicate that only 16 States have laws requiring mandatory reporting of elder abuse. Further results show that 63 percent of the States reported that the greatest hinderance to their ability to help abused older persons was lack of appropriate statutory authority—the second most frequent hinderance was lack of skilled staff, community resources, and funding. H.R. 769 is aimed at overcoming both of these major barriers faced by States in dealing with the problem of elder abuse. It is unfortunate that this kind of legislation is necessary to provide incentives for States to enact appropriate legislation dealing with the serious problem of elder abuse. However, as long as child abuse services are mandated by law and there is no Government mandate for elder abuse services, we will continue to see the vast majority of State protective service monies spent for child abuse services, while on a nationwide average less than 7 percent of State protective service funds are used for elder abuse services.

In the report released today on "Elder Abuse: The Hidden Problem," we have documented literally hundreds of examples of elder abuse, exploitation and neglect. Additionally, we will be hearing today from several older Americans who will be detailing first-hand accounts of their own examples of financial exploitation and physical abuse by their caregivers. In my own Congressional office in

Cleveland, Ohio, we have received many reports of older persons who were victims of financial and physical abuse. Many times we have received calls from social workers who suspect that an older person is being abused or financially exploited by a caregiver, but there is no legal recourse or established mechanism for initiating an investigation of suspected cases in Ohio. We have had reports of an 81 year old woman who lived with her son and daughter-in-law and was brought to the emergency room with a fractured skull reportedly resulting from a fall out of bed. In another instance an aide in a nursing home reported to our office that a 96 year old female patient had been raped by an employee in the nursing home. In a third instance, legal action was taken by the Legal Aid Society and a nursing home operator was convicted of stealing $500 from an 80 year old resident of his nursing home.

This operator is now serving a jail sentence, but he is only one of the unscrupulous nursing home operators who has been discovered and convicted. While I believe that the vast majority of nursing home operators are dedicated and honest people, we cannot ignore the fact that a few are unscrupulous and will use any opportunity they have to financially exploit their nursing home residents. Certainly these older Americans, as well as those who are exploited by unscrupulous caregivers in their own homes, deserve the protection of the law as would be provided by the Elder Abuse bill which I have introduced and hope to see passed.

Again, Chairman Burton, thank you for holding this hearing today to explore the sad realities of financial and physical abuse of our older Americans who deserve our highest honor and respect. Lastly, I would like to acknowledge the hard and fine work of those who have helped with this Congressional hearing, the two National Conferences on Elder Abuse, and the excellent report on "Elder Abuse: The Hidden Problem." Particularly, I would like to thank Carol Miller on my own staff and Kathy Gardner, Merrill Randol, and Val Halamandaris of the Aging Committee staff. Additionally, I appreciate the work and planning of Carolyn Farren, of the National Paralegal Institute, and Jim Bergman, of the Boston Legal Research and Services for the Elderly, who have made the two conferences so successful. Also, my sincere thanks to the Administration on Aging for the financial support of these conferences.

Chairman Burton. Thank you, Mary Rose.

Next is the "professor," as I call him, because when I went to San Francisco State College, he was a professor and the word was out, don't take Lantos, if you want to get an easy grade, and I never did.

It is a great pleasure to introduce a long-time friend, a person that I admired greatly from afar when I was a student, the Honorable Tom Lantos, newly elected Member of Congress from San Mateo County, and a tremendous addition to the House of Representatives.

STATEMENT OF REPRESENTATIVE TOM LANTOS

Mr. Lantos. Thank you, Mr. Chairman.

At the outset, I want to commend the chairman of our subcommittee for taking the leadership on this critical issue.

Congressman Burton has shown a remarkable degree of foresight and courage and leadership in this field which is only part of his general pattern of compassion.

Mr. Chairman, the quality, the caliber, the character of a society is measured by how it treats those of its members who are at the dawn of life, its children, how it theats those of its members who are in the shadows of life, its poor, it sick, its handicapped, and by how it treats those of its members who are in the twilight of life, its elderly.

Today, as we release the report of the first national investigation into the topic of elder abuse, we will be hearing from some highly qualified panels as we explore the problem of elder abuse in general and the financial abuse of the elders, in particular.

Unfortunately, a number of the people on the panel know about this abuse from first hand experience. They are people to whom we will be long indebted because of their willingness to share a personal experience with us in the hope that others might be spared a similar trauma. And their unselfishness is deeply appreciated.

The idea of abuse of older persons is as shocking as it is alien to the American spirit. Most people would be skeptical that this practice exists even on a limited scale.

Personally, I am appalled that this problem can exist in our Nation, among a people presumably dedicated to respect and protection of human life.

The report makes very difficult reading. There are hundreds of heart-wrenching illustrative examples which only begin to describe this hidden problem. Our report is just the tip of the iceberg, down to what for me is the most unbelievable evidence, which is that the perpetrators of these outrages are most often family members, frequently, a son or a daughter in the privacy of the home.

As one who was brought up on the biblical injunction that thou shall honor father and thy mother, it strained my imagination as I was working my way through the horrid examples.

The report includes examples of physical, psychological, and sexual abuse, of neglect, of financial abuse, and abrogation of personal rights.

The pattern is one of repeated abuse, rather than isolated incidents stemming from a momentary loss of patience. The cases include beatings, stabbings, rape, and murder. They include stories of severe malnutrition, deprivation of life sustaining medical care, and incredibly filthy living conditions. It is a chamber of horrors.

One of the most heartbreaking series of examples involved the elderly who lived independently until an injury or an illness necessitated a stay in the hospital. And, upon being discharged, many older Americans have learned that their families have literally sold their homes out from under them.

Equally heartbreaking are those family members who have their loved ones committed to a public institution as a means of obtaining their property. Many family members rationalize that it is a pity to waste money even if it belongs to the elderly and old people presumably near death.

In addition, the elderly are often vulnerable to legal trickery and fraud, occasionally at the hands of unscrupulous attorneys in collusion with family members.

Our report reveals that elder abuse may occur as frequently as child abuse but, for obvious reasons, it is not as frequently reported. On the average, there may be a million or several million cases each year. Perhaps 1 in 10 of our older citizens may be abused. And the abuse occurs nationwide and it occurs without regard to social, economic or racial characteristics.

Although our committee report provides us with vital information regarding this problem, we still have much to learn and much to do.

The cumulative weight of the evidence is devastating. The facts must not be ignored. We know that we need to question the appropriate Federal role. What can the Federal Government then do to prevent or respond to cases of elder abuse? How can we do it without violating individual freedom or interfering with State responsibilities?

I am, personally, interested in learning more about the likely causes of elder abuse and possible preventive action that we might take.

Recent studies on this issue seem to indicate that stress in many forms is a key factor. Life crises, economic uncertainties, limited resources, drugs, alcohol, and personality factors contribute to these festering sores in our society.

I have some questions, Mr. Chairman, about the State protective service that we designed to help abused adults. What are the possible legal ramifications in helping elder abuse victims who either will not or, because they fear reprisals, cannot ask for help.

It is clear that we urgently need more social services for families caring for an older person. We need to consider and support legislation such as H.R. 769 which would create a national center on adult abuse and provide appropriate assistance to the States.

In conclusion, there are many unanswered questions about the prevention of elder abuse. Hopefully, these hearings will begin to answer some of our questions and help us determine what the appropriate role of the Federal Government should be in dealing with elder abuse.

Arnold Toynbee reminded us that the character of a civilization is related to the way it treats its elders. I hope that our civilization will pass the test.

Thank you, Mr. Chairman.

Chairman BURTON. Thank you very much, Congressman Lantos.

I would like to identify the other people on the dais who will be testifying later.

First, to the left, far left, at least he was in the 1964 primary, a longtime friend of mine, John Delury, who is a consultant to the State Senate Committee on Aging, and is here representing Senator Henry Mello who could not be present.

Because Mr. Delury will not be testifying, if you want to make some opening remarks and submit something for the record on behalf of the senator, we would appreciate it, John.

Mr. DELURY. Thank you, Congressman Burton. As was indicated, there now exists a subcommittee on aging in the senate and Senator Henry Mello is chairing that subcommittee. This is the first specific assignment of the field of aging to some entity within the commitee structure of the State senate.

There has been a much longer development in the State assembly and the Chair of the assembly committee on aging is here and I know will be introduced to you.

This is a new development in the State senate. I am here to report back to Senator Mello so that he can be part of the process of defining what additional creative role can be played by State government in dealing with the very severe and troublesome problem that is being described this morning.

Thank you.

Chairman BURTON. Thank you, John.

Next, we will be hearing informal testimony from the chairman of the State assembly committee on aging, the Honorable Gerald Felando.

And we have you appearing with the State witnesses, or however you would like to do it.

Mr. FELANDO. I have a statement that I can read right now and then produce my witness later.

Chairman BURTON. That would be perfectly fine. Anytime Mr. Brown picks a chairman, that is all right with me.

Mr. FELANDO. There has also been a little talk about a Republican being selected as chairman of this committee, however, I think that as a Republican we can go a little bit further and we are having great results.

STATEMENT OF GERALD N. FELANDO, CHAIRMAN, CALIFORNIA STATE ASSEMBLY COMMITTEE ON AGING

Mr. FELANDO. I wish to thank you, Mr. Chairman, for giving me the opportunity and giving the State assembly the opportunity to testify before this committee.

I am chairman of the California State Assembly Committee on Aging. The topic of this hearing is of great concern to me, personally, and to all of the members of the subcommittee on aging.

Abuse of older persons has existed for many many years, but has only recently received public attention. We know that many cases go unreported, but we really do not know how widespread that problem is.

Cases are reported to California as an adult protective services program, but we do not know the age of the people subjected to abuse. I have introduced legislation to require that the aged abused persons be reported to the State.

There are two major problems concerning elder abuse. The first involves the reasons that older persons are abused. The reasons are circumstances that result in older persons being abused, or, as you are aware, they are really complex.

It can be a case of deliberate criminal abuse, or it can be a more subtle type of abuse resulting from the pressure or guilt felt by family or friends. And they are simply incapable emotionally or financially to care for the older person.

In America, we are only just beginning to address this problem by offering respite care providers. Adult day care centers are emerging and proving to be a great assistance to families who are trying to care for their own elderly. Other innovative programs are being designed to help older persons get back into the mainstream of the community.

These programs are, unfortunately, few and far between. I believe that the family support system should be encouraged or assisted in any way possible, whether through tax assistance or forms of community support.

The second problem involves reporting and treating abuse. The reporting and treating of abuse to older persons is sporadic at best. Most cases go unchecked, mainly because people in this society are afraid.

Older persons are afraid to seek help because of the threat of retribution or the unwillingness to turn in a family member or friend.

Neighbors are afraid to report suspected or blatant cases of abuse often because they would rather not get involved. State and federally support care givers such as Homemaker Chore or in-home supportive service workers sometimes do not report evidence of neglect or abuse.

Medical, social, or law enforcement officials do not report suspected cases of abuse, because they are afraid of being sued. This is an attitude which has gradually emerged in our society today and it is wrong.

The legislation that I have introduced also contains protection of and confidentiality for people who step forward to report suspected cases. I know that there is more work that can be done in that legislative arena and I pledge my efforts to correct the system in whatever way that I can.

We all know, however, the laws are only as good as the people who carry them out or the society that lives by those laws. We cannot legislate or regulate concern or caring. We cannot legislate empathy or compassion for our fellow man.

The Government alone cannot put an end to elderly abuse. It must be a partnership with individual citizens, private industry, and civic leaders.

I am encouraged by this hearing today and confidence that preceded it. I hope that we do not consider this to be an end unto itself, but rather a beginning; now a campaign must begin which reaches down to the very cities, neighborhoods, and homes of this Nation.

We must all be made keenly aware of what is happening to many older persons today. And we must make everyone aware that abuse will not be tolerated any longer.

Chairman **Burton**. Thank you.

Other people on the dais, to my immediate right, is Merrill Randol, who is the staff director of this subcommittee; to her right, is Kathy Gardner, professional staff member of the Aging Committee; then there is Val Halamandaris, senior counsel of the Aging Committee, friend of the elderly for years and one of the great exposers of nursing home and institutional abuse.

And Ed Villmoare, director of the Paralegal Institute, who has a few brief remarks.

Mr. **Felando**. Then we will make a statement at the end summing things up.

Chairman **Burton**. Mr. Villmoare.

Mr. **Villmoare.** On behalf of the four organizers of the just completed Conference on Elderly Abuse and Neglect, Legal Research and Services for the Elderly in Boston, my organization, the National Paralegal Institute in San Francisco, the UCLA/USC Long Term Care Gerontology Center, and the Harvard Medical School, I want to thank the House Subcommittee on Retirement Income and Employment for holding this hearing in conjunction with the conference.

We believe that the interaction between the conference and the hearing will help stimulate the special attention needed to address the challenge of elder abuse.

Later, during the testimony, Margaret O'Rourke and I will summarize briefly the recommendations developed during the conference. Thank you.

Chairman **Burton.** I see the assemblymen from that great county of Marin and parts of that equally great county, Sonoma, that have something in common with the very great county in the city of San Francisco. Dr. William Filante, it is nice to have you here.

Our first panel consists of persons who have encountered situations of abuse. They will be accompanied by their protective service workers.

Because of the certain concerns of reprisals or for their own personal reasons, many of them have expressed a desire to not have their full names made a part of the record, and we will honor that request.

I will go down the list of the persons that we will hear from. And then we will start the testimony that we are all so interested in.

We have Mrs. X. She will be joined by Ms. Leigh Hubert, executive director of Native Americans Senior Center in San Francisco, then Mrs. B of Palo Alto, who will be joined by Lucy Fitzpatrick, a legal worker with the Senior Adult Assistance in Palo Alto.

We will also hear from Mr. C of Hayward, who will be joined by Chuck Paussa, from Citizens for Better Nursing Home Care.

And, lastly, we will be hearing from Mr. Ephraim Lugo, from the San Jose Department of Social Services.

I am pleased to have you here. I understand that Reverend Pete is here in the audience and he will submit testimony for the record. He has been one of the great fighters of the injustices of the elderly for also many many years, as well as injustice everywhere.

And many of the things that we were able to accomplish in the State legislature on behalf of the elderly were due to the organizational efforts throughout the State of Reverend Peter, from the California Legislative Council of Older Americans, that he put together.

If there was ever a statue built by the elderly blind and disabled for or of this State for the one individual who has worked hardest and longest and helped accomplish the most, it is going to be that gentleman.

We have been through many fights together, lost a few and won a few. And ones we won are important to the standard of living of the elderly and the aged blind and disabled groups in the State of California.

We will first hear from Mrs. X and from Ms. Hubert. And if I could ask the TV people, as far as the witnesses wanting anonomity, to shoot them from the front would kind of blow that.

Ms. HUBERT. She does not care as long as they do not know her name.

Chairman BURTON. Fine.

Proceed, Ms. Hubert.

STATEMENT OF LEIGH HUBERT, PROGRAM DIRECTOR, NATIVE AMERICAN SENIORS CENTER, SAN FRANCISCO, CALIF.

Ms. HUBERT. Mrs. X is 65 years old. As you can see, she is a fairly small statured Indian lady.

Her problem that caused this disability began when her son came home to live with her from the Army. He was discharged under undesired circumstances and she took him in.

Everything went along pretty well until her payday. Then he demanded that he have the whole check. He demanded sexual gratification. He had already confiscated all of her medicines that she had had prior to this time for pain and arthritis and the usual things that go along with people who are elderly.

She lived upstairs so he broke her wrist, beating it over the bathtub. Then he broke most of the fingers in the other hand. He knocked her downstairs and the fellow downstairs came to see what had happened.

He heard him coming so he dragged her back upstairs. And when the fellow finally went away, then he threw her down again which did some more damage.

He would not take her to the hospital, so finally she agreed that she would let him cash the check if he would take her to the hospital, so he took her and told her that whatever you do, you keep your mouth shut. So she was so frightened she told them at the hospital that a stranger did it.

Things went along for 2 more weeks, when the other small part of her check came, and even worse happened that time. The oral copulation affair began again and all of the abuse, plus he had gotten ahold of some more dope and things like that between times, somehow, on his own, and he kept this woman prisoner all of this time.

He would take the telephone off when he went out and warned her as to what would happen to her if she said or did anything while he was gone to raise any fuss.

He took all of her furniture. He took her TV, everything that she had piece by piece and sold it. And so when the second altercation came, he absolutely threw her downstairs that time and was kicking her ribs and broke several of her ribs.

So the person that lived downstairs this time caught them. And he still would not take her to the doctor, but, of course, she was taken to the hospital.

This time she was afraid to lie to them, so she told them the truth, that he had done it. Since then, there has been a really sad court case.

She was in the court the day of the trial. And he walked up to her that day and said, keep your mouth shut, you dare say anything. That why she is trying to be so brave as to tell everyone all about this.

And since he is the only one that knows her actual name that would do her harm, we hoped that he can be kept confined until such time as her life is safe. And I realize that you think that this is a drastic thing and that it just might happen only in the Indian community.

Let me tell you something. I have worked in this work since I was a young woman. I am now 60 years old, myself. And I have seen black, white, pink, purple, and if there were Martians here, they would get the same thing. I have seen a lot of it. It happens every day.

And if you would like to ask her any questions, it is all right if you ask her noncommittal questions just so you do not get her upset.

Does the panel want to ask her any questions?

Chairman BURTON. I am sorry, but I fail to understand what a noncommittal question would be. In other words, I am sympathetic with what you are saying, but I do not know what to ask.

Ms. HUBERT. Would you like to ask her, for instance, the age of her son approximately? I know vaguely about it, but I do not know exactly how old he is and things like that.

I do not think that it is confined to age. I just think that it is done from the time that they are physically large enough to do this type of thing, until they are old enough to be getting it, themselves, but you might have some questions that I would not anticipate.

She wants to try to help you, if there is something that you want to know.

Chairman BURTON. I think that what we will do is hear from the panel first and then ask questions afterwards that might eliminate some redundancy.

Next, we will hear from Mrs. B.

STATEMENT OF LUCY FITZPATRICK, LEGAL WORKER, SENIOR ADULTS LEGAL ASSISTANCE, SAN JOSE, CALIF.

Ms. FITZPATRICK. My name is Lucy Fitzpatrick. I am with Senior Legal Assistance in San Jose.

I am here today with Steve Andasola of the independent and aging program of Santa Clara County and this is Mrs. B, our client, who is 86 years old.

Mrs. B does not read or write English, and she asked me to read a short statement of hers to you.

By way of background, I would first like to state that Mrs. B had her possessions converted, was placed under conservativeship and was admitted to a nursing home, all against her will, by her relatives and her neighbors. This is her statement.

STATEMENT OF MRS. B, GIVEN BY LUCY FITZPATRICK

Ms. FITZPATRICK [reading]. The neighbors and my relative made a trick on me that made me cry. They said, sleep at our house, then took out of my house everything that I own, everything, even the nail in the wall.

I went home. They had taken everything, even my citizenship paper, my husband's picture, all my pictures of all of my family. I got no clothes, nothing, only what I got on.

For maybe 4 or 5 days, I stayed in the house. I did not sleep or eat. I just stared at the clock.

One night when I went out, my relative grabbed me and shoved me into the car. He brought me to a place. I did not know the place before. I spent 11 months over there and it cost a lot of money.

You think I was sick? Sometimes my head hurt, but I have never been sick in all of my life. I spent 6 months there before I saw him once.

He went to the bank and he stole all of the money that I had. He and the neighbors took everything that I have got.

Now I am home. I have to buy furniture, buy sheets, buy clothing, buy everything.

That is the end of her statement, if you have any questions.

Chairman BURTON. We are going to have questions, I think, as we go through the panel.

Mr. C.

STATEMENT OF JAMES C. BRIDGEWATER, NURSING HOME RESIDENT

Mr. BRIDGEWATER. Good morning, Mr. Chairman and members of the committee and others.

My name is James C. Bridgewater. I reside at the nursing home in Hayward. I have been there for a few weeks. The only thing that I can say about the place is that it is very clean.

If there is any other evaluation of the place, I cannot say. My testimony here is about the treatment that I have received at the nursing home, for the last 6 years. And that was before I came to this new one.

It started back in 1974, December 27, 1974. I was at the VA Hospital in Martinez. And when they could not do any more for me, about my physical condition, they put me in this here rest home in Oakland. the name of this rest home in Oakland is Highview. It is 2 blocks from the back of Highland Hospital, and East Oakland.

I have rheumatoid arthritis and I am almost totally disabled. This is the shape that arthritis has left me in. I will just name a few of the things that it has done to me. My right leg is crooked. I have a crooked pelvis. And my knees are frozen. And I have lost all of my strength. And I cannot walk.

I was given an artificial knee in 1974. And I walked about 2 weeks and then it collapsed. I have not walked since then.

When I arrived at this nursing home there, I could sit there for approximately 20 minutes to eat. They would come, the nurses would come, and sit me up all right. Then I would finish eating. Then I would ask to lay back down. And they never would lay me back down. I don't know why they never did, but the pain got very bad.

I had to sit up 1 hour to 90 minutes before they would lay me back down. I was a new patient there and I could not understand why I was being treated this way, because I knew nobody there personally, and, as I said, I was new.

As time went on there and I began to gain a little bit of strength, I got up and I would move around in my electric wheelchair. I have seen two patients having an altercation one day in the hallway. One knocked the other one down and walked away.

The patient asked the nurse to help him up. Three nurses walked past the patient for at least 30 minutes to an hour, and no one picked him up, so I went over there with my wheelchair and asked him could he reach and grab hold of it and I was going to try to pull him up.

He did not have enough strength to pull himself up, so I reached down and tried to pull him up. And by trying to help him, I put myself back in bed, because I got hurt in the process of trying to help a sick brother that was injured in the same place that I was.

Those people there, at the time that I was in Highview, they have no compassion. They did not show no love or concern for nobody. The only thing that they are concerned about is when they got paid. And the less they could do for the patient, the better off they were.

Now I am a veteran of World War II. And I was in the medics for a long time. I went to nursing school at Fort Sam Houston, Tex.

Our first priority in the hospital was the patient. And we were taught to treat the patient with the utmost courtesy and do what you could for them, because they said then that one day you may be in the same position.

Those people that they have there at Highview and most of these nursing homes that I know of, those people are not trained for nothing. They just pick them up off of the street and give them a white gown or something and tell them to go to work. They don't know how to speak to people. They do not know how to handle you and they do not care. It is just that way.

There is nothing that you can do about it. Most of the other people that were in there, they were elderly people. They were a lot older than I was. They were scared to speak up. I am not a senior citizen. I have had arthritis for 17 years and I am 52 years old, so I am not a senior citizen, but I figured, like this here, I was a young man when I went there and I was treated like I was dirt. And they treated them older people worse than they did me.

And there was nothing that I could do to help. The State would come in and the State would evidently see what they wanted to see. I was there for 6 years.

And they walked in, they could see that the place was in a shambles, bad shape, and they would only write them up maybe if they see cockroaches running around or some ants on the floor or something of that sort.

The food was terrible. It was not worth eating, but you did not have a choice. It would fill you up and that is about all it did. It did not give you any nutrition whatsoever and most of the people there were starving for nutrition.

They wasn't starving because they were hungry. They would eat the food, but the food was doing you no good. As I said, I believe the patients were scared.

And one night there, around 2 o'clock in the morning, a fellow came in off the street. His eyes were all glassy and he grabbed one of the nurses and he put a knife upon her throat and he threatened to cut her, and that went on for about an hour. The nurses were jumping off the ramp, two stories up, trying to get out of his way, and things like that up there. They said that the man was actually crazy.

I am talking about the nurses in this here home. I don't want people to think that all of the nurses were the same, because they had a nurse there. See she was, her life was threatened that if she tried to straighten things out and she talked to me about it. I told her that it was best to quit, because I could not help protect her, because I had trouble protecting myself as a man and I knew I could do nothing to help her.

She then quit her job and she left the work, working with patients, but she was threatened by the other personnel there. If she opened her mouth, they were going to get her and it was just that way.

The supervisory personnel there, they showed no interest in no one. They was only concerned about themselves, because in the course of the 6 years that I was there, they had about 16 supervisors. And that is changing supervision too much for one job.

Chairman **Burton**. Thank you, sir.

Next, there is one witness who I think at this time it would make a great deal of sense to bring her up.

Then we will hear from Mr. Lugo and then we will be able to ask questions.

Mrs. D.

Mr. **Felando**. Would you bring Mrs. D up, please.

Charlotte Humphrey will be speaking for her, while she is coming forward. Charlotte has been the director of this agency on aging for 4 years. She is here to tell us about Mrs. D's experience, abuse, and how fully prepared communities are to help abused older people.

Mrs. D is 93 years of age and she is a warm and astute person.

Mrs. D has asked that Charlotte answer any question for her.

Charlotte.

STATEMENT OF CHARLOTTE HUMPHREY, DIRECTOR, AREA AGENCY ON AGING, SACRAMENTO, CALIF.

Ms. **Humphrey**. Thank you, gentlemen and ladies.

My friend with me today is Rosie. She is 92 years old and the mother of 12 or 13 children. Six of them are still living.

I met Rosie several months ago under a set of strange circumstances. Rosie and her dog had been left deserted on the streets of a small town in the valley by her daughter. Rosie had nowhere to go, no money. Even her memory seemed to fail her. Her daughter had left on a 3-week trip with a friend.

My office was called about 12:30 on a rainy Tuesday afternoon. As the bureaucracy begins to wind down about that time and as there was no existing plan in our county for deserted 92-year-olds, I picked up Rosie and took her to my home for dinner and to spend the night, until we could find placement for her the next day.

During that evening and many times since, Rosie has unraveled a horror story of neglect and abuse while living with her daughter.

According to Rosie, 2 weeks prior to being deserted on the streets, she had been locked out of her daughter's home overnight in the rain. She had walked 2 miles for help and then, finding none, as they lived in the country, she walked back and begged to get in.

Her begging caused some of the neighbors to come up. They witnessed this abuse but did not wish to get involved. This was only the beginning to Rosie's comments over the last 2 months.

Abuse has included taking her social security checks and threatening to kill her if she did not endorse them, or beating her into submission.

And then, more subtly, there was the giving her only a thin blanket during the winter for her bed. She was always cold and complained of being cold.

They told her that there was a water shortage so that she could not bathe or wash her hair for long periods of time and then they rationed her food. She was only given a minimum amount to eat and then there was very painful physical abuse.

Rosie does not always talk about her abuse or the bad times. She loves her daughter and her family. She talks about the good times. She makes excuses for her daughter's behavior like many a good mother has done.

Rosie was placed in a retirement home about 2 blocks from my home. Her social security proves to be adequate to pay for the room and board, and a few expenses that she has. She is a frequent guest, as I still have her dog. The retirement homes does not take dogs.

Rosie loves her dog very much, says that Snoopy saved her life the night that she was locked out of the house in the rain.

As a result of Rosie's unfortunate desertion, the county board of supervisors set up an elder abuse council to specifically design a plan and seek funding for the many Rosie's that exist.

Unfortunately, like Rosie, the many, many abused elderly continue to make excuses and try to hide the abuse of their family and their loved ones.

Rosie and I appreciate very much being invited here today. Thank you very much.

Chairman Burton. Thank you.

Mr. Paussa.

STATEMENT OF CHUCK PAUSSA, CITIZENS FOR BETTER NURSING HOME CARE, OAKLAND, CALIF.

Mr. Paussa. My name is Chuck Paussa. And I work for the Citizens for Better Nursing Home Care which is the ombudsman program for Alameda County.

We are the only people given access to nursing homes by law. And without that law many nursing homes would not let us in to find out about abuses like Mr. Bridgewater had told us about.

Most of the abuses that are in nursing homes are of simple neglect. We find people laying around with bed sores or very filthy, have not been washed in weeks. They do not receive their physical therapy. Their buzzers are not working and there is a severe shortage of staff.

Chairman Burton. Could that be the result of what you said, short staffing standards which have brought about the neglect, as opposed to intentional neglect?

Mr. Paussa. Often, yes, but most of our cases are that the staff does not pay attention. It is not really intentional. They just walk on by, pretending that it is not in existence.

Chairman Burton. Thank you, sorry to interrupt.

Mr. Paussa. The real problem is not that the staff is bad or the nursing home is bad. We find that the problem is that there is no one around to come in and ask people what is wrong with you, to treat people with respect, and to notice when things like this happen.

There are only 36 of us in Alameda County and we have to cover 60-something nursing homes. We only cover these skilled nursing facilities. We do not cover residential care.

There are many other groups who would like to do what we do, the friendly visitors groups, but they cannot go into many nursing homes, because the nursing homes do not want them in there raising trouble, causing things to happen. They are not allowed to or they are not backed up by law to enter the nursing homes.

It is not because there are not people willing to do that. There are people willing to do it, but it, the problem, is that the laws are not there to back us up so that we can go in.

Also, when we do report the problems, we do not report most of our problems, but solve them in-house by threatening to report or by just going in and saying, you must do this.

When we do report problems, often they are not prosecuted because of the problems in prosecution. The regulations are very vague so that nursing homes can say, this, or they go back and forth and say, this is not really a violation and they are given the chance to do something about it before it happens. That is my statement.

Chairman Burton. Thank you, Mr. Paussa.

Mr. Lugo.

STATEMENT OF EPHRAIM LUGO, SOCIAL WORKER, DEPARTMENT OF SOCIAL SERVICES, SAN JOSE, CALIF.

Mr. Lugo. Mr. Chairman, members of the subcommittee, good morning, and thank you for inviting me to come before you to testify on the problem of physical abuse and financial exploitation of our elderly.

My name is Ehpraim Lugo. I am a social worker from San Jose and I am employed by the Department of Social Services in Santa Clara County.

I am an adult protective social services worker. I had originally planned to accompany and to support the testimony to be given before you by one of my clients who, unfortunately, at the last moment was unable to come here due to ill health.

I would like to present to you today, however, a brief summary of his problem as well as summarize two other cases to give you an idea of the extent of the problem, that is, of physical abuse and financial exploitation of the elderly in our community.

The client whom I was to accompany today is a 71-year-old former cab driver from Chicago, who came to the West after the death of his spouse in 1964. He lives alone in a mobile home in San Jose. He has a married daughter living in Chicago, and a son who was married and lives in San Jose also.

My client's problem begins several years ago when his son, who has a drinking problem, began borrowing money from him.

The borrowing soon became a problem to my client as his only income is social security benefits and SSI. When my client began refusing the requests for money, the results were beatings, and money, as well as other valuables, were taken from him forcefully by his son.

The problem was reported to us by a friend and neighbor of my client. In discussing the situation with her, she was asked if she had actually witnessed the son hitting his father. Her reply was: "No, I have never actually witnessed the son's striking his father, but I live not too far away and I can say that I did hear the sound of flesh striking flesh."

When I interviewed my client, I asked him if the reports of physical beatings were true. He replied; "No man can hit me and get away with it, least of all my son." However, after talking for a while longer, my client shamefully hung his head and tearfully admitted; "Yes, my son hits me, but it is because he drinks or he needs to drink so badly."

The second case that I would like to present to you is a case of 79-year-old black man, a veteran who has a 100-percent service-connected disability, a man who became permanently disabled while serving in the military.

A year and half ago, he became even further disabled by a stroke. The results of the stroke caused paralysis of one arm, his left, and the right leg and left him totally unable to care for himself.

A brother and his wife offered to help him. They agreed to take care of my client and to meet all of his needs, handle his money for him, and to help in whatever way was necessary.

To do this, they required or they asked my client to agree to open up a joint savings account into which my client's veterans pension checks and his social security checks were deposited. They were to withdraw money from the savings account to pay my client's expenses, all of his bills and other financial obligations.

After nearly 1 year of having this responsibility, my client's brother, with the exception of some utilities bills and groceries, had paid for nothing, although withdrawing large sums of money from the savings account. My client's brother also, through the assistance of a private attorney, had himself named conservator for my client.

When we became involved, we found that the mortgage payments on the house of my client were 6 months in arrears, and that he had no knowledge of what he owed or who he owed money to, since the bills were being sent to his brother's home for payment, or so he thought.

Since we have become involved, we have been able to have the brother removed as the conservator and we have been able to get the court to name the Santa Clara County Public Guardian's Office as conservator for my client.

The third and last case that I wish to summarize is a case of 76-year-old Mexican widow who until 1975 had her 45-year-old emotionally disturbed daughter living at home with her.

This case was referred to us by a physician from one of the local hospitals as he suspected that my client had been physically abused by her daughter.

The physician noted that he found numerous bruises and contusions on her face, head, and upper body, when my client was taken to the emergency room by another one of her other daughters.

Since my client speaks no English, the physician, using the daughter to interpret for him, asked if she had been beaten by the daughter. As the daughter was translating the question to my client, the physician stated that the look of fear that came over my client's face when she understood the question was an immediate confirmation of what he suspected even though my client vehemently denied the obvious.

She did later admit to her daughter in the privacy of the automobile on the way home from the hospital that, yes, she had been kept up all of the previous night by her daughter who had her backed into a corner and slapped her continuously, pushed her repeatedly up against a wall and at the same time demanded that her mother sign a paper giving the home in which they were both living to her.

As I think I have illustrated the abusive behavior and financial exploitation of our elderly, appears to occur over all racial and ethnic groups and is a problem which many of us who work in that field believe is only beginning to surface. Many feel that we are barely scratching the surface and that beneath lies a problem of gross dimensions.

No one is willing to admit that our elderly are treated cruelly. Most feel that this happens only in institutions by unrelated, uncaring hirelings and are least of all treated cruelly by their own kin.

It is thought to happen only in a few cases like the old senile mother who continuously wet and soiled herself, while standing beside the toilet. She would bring her son, with whom she lived with tears of frustration which later became blows of frustration and of shame and of guilt. As the problem of child abuse, abuse of the elderly is a phenomenon which requires careful study. We need to know more of the abusive behavior toward our elderly. I spoke of some very obvious behavior on the part of relatives who exhibited in two cases some very obvious and common problem behavior.

But what of the cases mainly unreported as we have heard this morning, in which elders are abused by seemingly kind, loving relatives?

If all of our elderly and their families are to realize the pleasures of their golden years, we must find the answers to some of the questions that have been raised in this hearing in this conference, and I am confident that we will.

Ms. OAKAR. Thank you very much, Mr. Lugo.

I am going to begin by asking a few questions. Let me ask Mrs. X, for the moment, does she have any other children?

Mrs. X. Pardon.

Ms. OAKAR. Do you have any other children?

Mrs. X. Yes, I have.

Ms. OAKAR. What was their response to the abuse?

Mrs. X. They did not believe it.

Ms. OAKAR. They did not believe it?

Mrs. X. No.

Ms. OAKAR. So you really could not go to them?

Mrs. X. No.

Ms. OAKAR. For help.

Mrs. X. No.

Ms. OAKAR. How did you finally get help?

Mrs. X. I finally asked the nurse at the hospital and the doctor. And he said, that was your son, that was the second time, and I said yes. And I started to cry.

It all started up with him drinking and taking drugs. And he took my money. And I had to satisfy his sexual needs. He spoke obscene language to me.

Ms. Oakar. Mrs. X, we really want to thank you for being here. We know this is hard for you.

As I think Ms. Hubert mentioned, your being here is very important to the other thousands of people who are in the same boat that you are, so thank you very much.

I want to ask Mrs. B, then, a question. Has she received her possessions back that were taken away from her or was there any legal recourse that she could turn to.

Ms. Fitzpatrick. She received back most of the money that was taken, because it was placed into a conservatorship account after her relative became the conservator. And most of that was then returned that was not used.

As far as her possessions, they cannot be recovered. There may be an action against the relative who took them, but we have not determined, as yet, whether to pursue that action for her.

Ms. Oakar. How did she come in contact with some help then?

Ms. Fitzpatrick. The ombudsman of the nursing home contacted our office. We helped arrange to have the public defender terminate the conservatorship and we then represented her at the conservatorship's final accounting and were able to have several thousands of dollars of proposed conservatorship fees disallowed.

The Independent Aging people helped settle her back into her home. We also helped her regain possession of her home.

Ms. Oakar. So the kinds of services that you provide are very very important, aren't they? We hope there is no crush in the budget, or they would not have any recourse, would they?

Ms. Fitzpatrick. Thank you for that.

Ms. Oakar. That is for sure.

I was interested in your mentioning the ombudsman program and, of course, Mr. Prussa who is obviously involved, because we have a very fine program in Cleveland. They are always walking on a tightrope trying to get funded, but in my own city we had the case of an individual nursing home operator who was confiscating the checks of the elderly. He is now serving time in prison, thanks to the ombudsman program.

It is a great program.

I was interested in the fact that both Mr. Lugo and Mrs. B have mentioned cases with language handicaps and we have a bill related to helping the elderly with respect to language handicaps. It is a very real problem, isn't it?

Ms. Fitzpatrick. May I comment on that?

Ms. Oakar. Sure.

Ms. Fitzpatrick. Mrs. B does not read or write English. And we believe that she gave her relative a power of attorney without realizing it, a voluntary conservatorship, and she also signed her admission papers into the nursing home without realizing what they really were, because they were printed in English.

Ms. OAKAR. Very interesting.

Would you like to comment on a language handicap, Mr. Lugo? Is that a proven problem with the additional difficulty of people with handicaps?

Mr. LUGO. Yes; it is, because so many of my clients are Spanish speaking we often find that in many cases a client will have to take the word of a son, daughter, or some other relative that a document that has been presented to him or her for signature really states what they say it does, without really knowing what effect this document is going to have, once they sign.

My wife works with an agency that provides assistance to persons whose homes are going into foreclosure. She was telling me about an elderly Mexican woman who could not read or write, who knows absolutely no English, but who has signed all of the documents necessary turning her property over to a son, who is now in the process of losing the home through foreclosure.

This is one example. There are many that we come across routinely.

Ms. OAKAR. Mr. C, obviously you have had some training with respect to patient care?

Mr. BRIDGEWATER. Yes. I have 6 years.

Ms. OAKAR. You, yourself have been victimized by poor nursing care?

Mr. BRIDGEWATER. Yes.

Ms. OAKAR. What kind of advice would you give? What would you like to see happen to the patient's rights, so the patient's rights are protected? What changes would you like to make so that this will not be happening?

Mr. BRIDGEWATER. One of the changes is that they ought to give those people a course in human relationship, learn them how to get along with others.

In those homes, you have people from all walks of life in there and when they do come in, they are bringing these new people. And these new people turn up their nose at those people because they are down flat on their back. And they feel they have never been nothing in their life.

You find some other influential people in these rest homes that were very successful in their younger lives and something has happened to them mentally or physically, but that don't make them no old rag that you can kick around. They have feelings and they would like to be treated like humans. And they are still human.

Ms. OAKAR. But you had no one to go to at this nursing home that was in a position of authority? Were you afraid to tell the administrator?

Mr. BRIDGEWATER. They would call and tell them but they would not do anything about it. That is what surprised me. And the supervisory personnel was turning over faster than the people that came in to wait on the patients sometimes around there.

Every time we looked up, we had a new supervisory staff in the office. And it got so bad there that they were coming in the rooms and pulling the rings off the women's fingers at night, stealing TV's, and everything.

I lost a brand new TV in the place. I stepped out of the room. I wasn't gone more than 10 minutes. And I came back in my wheelchair, I seen the door closing and my TV was gone. I could not do nothing about it.

Ms. **Oakar.** That is a form of financial abuse, isn't it?

Mr. **Bridgewater.** That is right.

Ms. **Oakar.** Thank you.

I have just one last question for Mrs. D. Does she—and it is probably one of the more heartless stories, I suppose, as much as you think that you have heard them all—does she have any other children or grandchildren or great grandchildren who would have been aware of this difficulty?

Ms. **Humphrey.** She has other children. Rosie has other children. They, themselves, are elderly, like 60 or 70. The grandchildren, she has many, but they are all scattered.

And she really does not have recall about where they are.

Ms. **Oakar.** How old was the daughter who deserted her?

Ms. **Humphrey.** Fifty-three.

Ms. **Oakar.** She was 53, and the others are not able or not interested to care for her?

Ms. **Humphrey.** She has one in Yuma that would like to take care of her, but Rosie said that she would get the same treatment from that daughter as the other one.

She has another daughter that is up north who just underwent cancer surgery and, herself, is not well. They are older as well.

Ms. **Oakar.** So your problem is that when you do not have a crisis center or anything, when you were confronted with the problem and had nowhere to place her that evening, you, yourself, had to take on the responsibility.

You know, there were some legal ramifications in what you did. You really took a gamble, didn't you?

Ms. **Humphrey.** Yes.

Ms. **Oakar.** Because you are not protected under the law, are you?

Ms. **Humphrey.** No.

Ms. **Oakar.** For that sort of thing.

Ms. **Humphrey.** No.

Ms. **Oakar.** Which is really very courageous, I must say. Have you had a chance now to finally place her in a better situation?

Ms. **Humphrey.** Yes; she is placed in a retirement home several blocks from my home. The problem is with the dog. She really loves that dog. And, of course, the retirement home does not allow dogs and that is very much a part of Rosie's life. And so as a result, her being within 2 blocks, she comes over and visits with the dog.

Ms. **Oakar.** Thank you. Mr. Lantos.

Mr. **Lantos.** Thank you. I do not have any specific questions to ask any of our witnesses, but I would like to make an observation.

In the first place, I think that we all owe all of you a deep debt of gratitude for being willing to go through this experience which is a very difficult one for each of you.

And I want to particularly comment on the extent of compassion and professionalism which I see displayed by the women and men who have accompanied our witnesses.

I must say, Ms. Humphrey, you made my day, because at a time when public officials and so-called bureaucrats are belittled day in and day out, your story of human warmth and compassion is a beautiful one.

And, finally, I would like to make a suggestion to the Chair, if I may. I suggest that both the written copy of these hearings and selected highlights of the tape be sent to our new budget director, Mr. David Stockman, of the Office of Management and Budget.

Ms. **Oakar.** If you will yield for a second, you know that Mr. Stockman is going to appear before our Aging Committee on Monday, so maybe we can talk to him then.

Mr. **Lantos.** Yes, I know that, Madam Chair, and I would very much hope that my colleague, Mr. Burton, will request his most able staff, if at all possible, to prepare selected highlights of the tape which we can then present to Mr. Stockman. I think that it would be singularly educational and get involved with some human problems. Thank you.

Chairman **Burton.** I think the staff will do that. My own subcommittee has a hearing that day on an aviation safety matter. And so I guess we will leave Mary Rose to meet and deal with David.

Actually, it is very tough to educate a kid who knows everything and Dave does, but I consider him a friend and do have great respect for him.

I think it is our duty to help educate Dave, really, that things are not solved with a magic wand, be they economic problems or other things and there are some real human needs that must be met. And I worked on the welfare reform program in this State with our Governor, not President Reagan, and we are talking about the truly needy.

And Governor Reagan has always supported help for the truly needy. I think that it is easy to see that this representative group of people appearing before the subcommittee are not the greedy, but the truly needy.

Dave has even said that he wants to help them.

Mr. **Lantos.** Thank you, Mr. Chairman.

Ms. **Oakar.** We do have a request from our assemblymen for some questions. We are running overtime and I will wield the gavel a little more strongly.

I am going to limit your questions to one question, if I may, because we are running almost to 11:30, and we have a whole series of other people. And we also have a time problem with respect to this room.

I will be happy to yield to whomever would like to ask the question.

Mr. **Felando.** Do I understand that between the two of us we have one question?

Ms. **Oakar.** No; just one question each.

I can get away with it.

Mr. **Felando.** You were talking about Stockman moving that ax, but you are pretty good with it, yourself, Madam Chairman.

Chairman **Burton.** I would say that it is a rare privilege for a member of the State legislation to sit with the House subcommittee, so I think that it is fair. I would not worry about being able to ask one or two questions. And that goes for my good friend, Bill Filante.

I would not really try to come down too hard on Mary Rose, because you talk about an ax. She comes from a pretty tough area of Cleveland.

Nobody wants really to mess with her and I would just advise my friends of that.

Mr. **Felando.** I just would have one comment or one question for Mrs. X. Would Mrs. X support society placing her son in prison for life?

Mrs. X. Yes, I would.

Mr. **Felando.** Thank you.

Mr. **Filante.** Thank you, Madam Chairwoman, and thank you, Congressman. I appreciate the invitation that was given to all members of the assembly committee on aging to participate in this conference. It is very valuable.

I felt that it was absolutely necessary for me to come here even though I could not stay for the whole meeting, because I am the only physician in this legislature in California.

Because I have faced this problem as a physician for over 30 years, it is my opinion, frankly, that people are not worse people today than they used to be. I think that the same people are in our society today as were here before, but I think that things have changed in the last 30 years.

I have a problem in trying to take care of the elderly. I very much like the comment that was just made. And I would simply like to refer to the comment that was made on the budget, because the nursing homes that in many cases are abusing their patients, or elderly, and what have you, in some cases have to.

They are caught between a rock and a hard place, because of rates they are allowed to charge and wages that they are allowed to pay.

I really appreciate the elderly coming in and telling us what the situation is. There was a case where a nursing home made an effort to upgrade their help and train them more so they can take care of the people and then, as soon as they were trained, since they could not and were not allowed to pay them any more, people left to go to work for an acute hospital. That is a case where they simply are not paid enough.

I have one nursing home—that I have been trying to help—run by an individual. It is not a chain or a big corporation, and he has to go to the bank every month to borrow money to meet his payroll. He cannot take in enough money to do it.

So there is a mixture of things going on out there. The Medi-Cal problem, in terms of budget, is that our budget, although in this State it is 5 billion—half of it coming from the Federal Government, thankfully, and half from our State—could be cut by 20 percent and not cut one wit of care if we were to change, we are able to change, and get rid of some of the bureaucracy there.

It has now been proposed in the State of Massachusetts. I proposed it here a couple of years ago.

I would like to increase the care and not save quite so much money, but we are at an impasse right now, because people do not understand that you need an incentive not only for people to come in and tell us what the trouble is, but for providers to upgrade their care.

And I would hope that those of you who represent not only individuals but groups today can work with us either at the State or at the Federal level. Dr. Felando and I are both on the Aging Committee and on the Health Committee, and working desperately to change this situation, but I would just like to close, after I have asked for your help on the budget problems and the administration problems on the care of the elderly.

I would like to close with one note that I hope will not go unnoticed, and that is these horrible and sickening reminders of what has happened to many of our people in society is just a small portion of what I call abuse of the elderly by society at large.

Within the last 30 years, we have created an entire generation of the elderly who are now destitute who, in former generations, could take care of themselves.

We have thrown them out of their jobs, because they have reached a certain age. We have thrown them out of housing areas. They can live in some special place.

And we have actually encouraged people to get along and not learn English and to vote or whatever it is without learning English, and then be placed in this horrible situation of being manipulated by families or people or government.

And it is a crime against the elderly, but in this case, it is perpetrated by the entire society. All of us in this room are part of that. And I would hope that we can kind of change our attitude and say that the elderly have to be taken care of which means to give them a chance.

Thank you, Mr. Chairman and Madame Chairman.

Ms. Oakar. Thank you, doctor.

I must say that it is great to see people of a variety of professions in the assembly, I think that it is very "healthy", if you will excuse the pun.

Mr. DeLury. It is a small sacrifice.

I have one brief question. I noticed that in the example of Mrs. B and in the example that Mr. Lugo presented that there was the apparent abuse of conservatorship.

Do you have any recommendations with respect to how prior investigation or whatever could occur in respect to conservatorship to prevent this kind of thing from happening?

Mrs. Fitzpatrick. I would just suggest that the investigators who go out even on voluntary conservatorships do a better job, be required to do a better job, to really discuss with the person and find out what their situation is and if they really require such a conservatorship. I do not think that was done in this case.

If they had spent much time with Mrs. B, they would have discovered that she did not need a conservatorship and that she would have rather been at home.

Mr. Lugo. In my client's case, the court interviewer did go out. She spoke with my client and noted that my client did not want his brother named as his conservator. The judge went ahead and acted against my client's wishes. And we were on that basis, and because his brother was not handling anything, able to have him removed.

Ms. Oakar. Thank you very much.

And on behalf of the subcommittee, we certainly want to thank all of you for adding to our testimony and that, hopefully, will lead to some type of solution at a Federal level and will compliment what the gentlemen are trying to do in the assembly here in California.

That is the intention of our bill, to compliment what the State does. I am happy to see that you have introduced an elderly prevention of abuse bill also on a State level which is very important. Thank you very much.

Ms. OAKAR. Our last panel before receiving the summary of the conference recommendations consists of legal service experts.

We will hear from George Alexander, the dean of Santa Clara Law School. Dean Alexander will discuss with us a number of practices which are employed for people who are judged no longer able to care for themselves.

He will be joined for the panel by Alfred Chiplin of the National Senior Citizens Law Center.

And also on the panel will be Mike Gilfix, the director of the Palo Alto Senior Adults Legal Assistance;

Bruce Feder, an attorney with the Legal Assistance for the Elderly, San Francisco;

Both will describe to the subcommittee experiences that they have encountered in attempting to provide legal assistance for the abused elder persons.

So if you gentlemen will come up, we would like to hear your testimony.

Some of you are coming up and I notice that some of you will be leaving the conference and I, certainly would like to say how much we have appreciated the fine conference that was held here and also in Boston. And we really certainly need your help, those of you who are in the audience, I know that some of you will be leaving to catch planes and so on, but you are the providers and we certainly welcome the direction you give us.

We will be happy to take your testimony. If you have written testimony and want to summarize it, we would put your entire testimony in the record, but you can proceed in any way that you would like.

We will begin with Mr. Alexander.

STATEMENT OF GEORGE ALEXANDER, DEAN, SANTA CLARA LAW SCHOOL, SANTA CLARA, CALIF.

Mr. ALEXANDER. Good morning.

I want to thank you and the committee for having this time made available to me to express my point of view. I will try to be fairly brief and would be more than happy to respond to any questions that you might have.

The principal concern that I would like to share with you really takes off on the last question asked; mainly, what is to be done about conservatorship?

Conservatorship has been a device that has particularly been used in all of the States of the United States that has greatly disadvantaged the elderly in the management of their lives.

Through conservatorship the elderly have been robbed of their property and wrested of control of their health and other care needs. And very often the very act of conservatorship, itself, has caused tremendous damage.

I would like to trace very quickly how we got ourselves into that position and suggest a small path that might lead us out.

The biggest problem, of course, comes from the fact that we conceive of the institution of conservatorship as beneficial, rather like we conceive of a number of so-called services for the elderly as beneficial before we have the opportunity better to examine them.

Conceiving of the services as beneficial, we then broaden it to the extent possibly legally in order to make it available. It is made available to a large range of people who can bring a petition for conservatorship and it applies to a tremendous range of potential wards that may be put under conservatorship for a variety of reasons and in many States, simply because they are old.

They are incompetent, that statute says, because of old age, Conservators in some States make such basic decisions as to whether to institutionalize their elderly wards, rather than having decisions made by the wards themselves.

The kinds of activity for which we normally require a person's consent are consented to by others—often others, as you have heard, who have interests that fundamentally adverse to the interest of their wards.

There is, of course, in many cases, a financial conflict between the conservators and the conservatees, the conservators often being the beneficiaries of whatever wealth will be left over, that is, after the ward has passed away.

We would normally look to those who stand to benefit to direct the lives of those whose funds that they hope to acquire, but in this area we do.

Similarly, with respect to health care, we allow conservators in many States, I am pleased to say not in California, involuntarily to hospitalize their wards as a means of taking care of their problem.

What they may succeed in doing in many cases simply is removing the elderly from homes in which they are a bother. The elderly people can then be put somewhere else, without their consent at all, somewhere else where they can languish without treatment—there is no treatment for being old—and very often suffer great deprivation.

Now, lawyers have begun to see the problems in conservatorship lately, I am pleased to say, and I wish I could say that they have found a good solution. I think they have not, but in the main what lawyers have done is to look to due process as a way of saving people from conservatorship.

Can't we have better investigations? Can't we have more hearings? Can't we involve more lawyers?

Of course we can. The problem is that in this area, what we are involving outsiders in, is an issue so fundamentally imprecise and so fundamentally difficult to deal with that due process simply does not help much.

Now it certainly is better to exclude from conservatorship proceedings people who obviously are totally competent, but those cases are not the ones of which we normally hear.

And in other cases, such questions as whether a person is or is not competent is not either a medical question or a legal question that anyone can answer with any skill.

A physician knows how to treat a person, but a physician cannot make a professional judgment about how that person is able to live in society, able to react to financial stress and the like.

A lawyer, on the other hand, can probably help illuminate any precisely put legal issue. But competency is not one of them. The result is that while we have improved the procedure, the process simply will not benefit from legal help.

What is needed is a reintroduction of individual autonomy which is somehow the last thing that people think about in this area. People need to be given back the management of their lives.

And the way that you give people back the management of their lives is to provide, at every opportunity, a method for people to express their self-determination.

I have suggested in an article which I have left with the committee as my testimony a single device that might lead in that direction. I do not come to promote that idea. I come to promote, instead, the notion that we need to think again about making devices available by which people can tell us what they want and especially so at a time when nobody had or has any doubt about their clarity of mind.

The more we look to them and to their decisions to guide us at a time when we have become confused about their competence the better it seems to me treatment for the elderly will be.

Thank you very much.

Ms. OAKAR. Thank you, Mr. Alexander. You had very interesting testimony.

Mr. FELANDO. May I add just one comment to what the Dean has said?

Ms. OAKAR. Just so that we have a sense of direction here, we will hear from all of the panel and then we will be happy to respect your question.

Mr. FELANDO. This was just a short statement in response to what he had said.

Ms. OAKAR. I would rather proceed in this other matter, because there might be related questions or a point that is raised.

Mr. Alexander, we will insert your booklet that you brought with you at this point into the record.

[The material submitted by Mr. Alexander, "Premature Probate: A Different Perspective on Guardianship for the Elderly," which was reprinted from the Stanford Law Review, Volume 31, No. 6, July 1979, has been retained in committee files.]

STATEMENT OF ALFRED CHIPLIN, JR., NATIONAL SENIOR CITIZENS LAW CENTER, LOS ANGELES, CALIF.

Mr. CHIPLIN. My name is Alfred Chiplin.

I am an attorney with the National Senior Citizens Law Center in Los Angeles, Calif.

I would like to say that I have prepared testimony that I have submitted to your staff to be included in the record on behalf of myself and Neal Dudovitz.

Ms. OAKAR. Without objection.

Mr. CHIPLIN. I have some general concerns that follow in the same vein as the Dean who just spoke.

It is our feeling that conservatorship, guardianships, the representative payee process, and the use of various power of attorney provisions are often misued and abused by people in their efforts to provide solutions in elder abuse cases.

It is our feeling that legislative proposals designed to remedy elder abuse be mindful of due process issues such as the elder's right in notice and an opportunity to contest the imposition of any incursion on their liberty, including their ability to manage their affairs.

It is very important that the people who are responsible for investigating and reporting elder abuse cases carefully evaluate the situation, and that the investigators do not make presumptions about the competency or incomptency of the elders involved.

Often, we equate being elderly with being a child. This is just not the case.

There seems to be very much in play the feeling that being old really is tantamount to being incompetent.

I am also concerned that when we talk about mandatory reporting laws and begin to move in that direction of enacting them, that we are careful to make sure that our society has put in place efficient and effective service so that when you go into someone's home with the suggestion or promise of help that we can actually deliver that service.

The cost of putting those services in place represents a significant financial commitment. This too should be considered.

In closing, I would like to say that I think it is important that we approach any notion of reporting laws, protective service devices, and the like, with extreme caution. We should evaluate the services and procedures that we already have in order to see if perhaps we already have the basic rudiments of the protections that we need.

Thank you very much.

[The prepared statement of Mr. Chiplin follows:]

PREPARED STATEMENT OF NEAL S. DUDOVITZ AND ALFRED CHIPLIN, JR., OF THE NATIONAL SENIOR CITIZENS LAW CENTER, LOS ANGELES, CALIF.

We are Neal S. Dudovitz and Alfred J. Chiplin, Jr., attorneys with the Los Angeles office of the National Senior Citizens Law Center.

As this committee well knows, the National Senior Citizens Law Center is a national support center, with offices in Los Angeles and Washington, D.C., which specializes in legal problems of elderly poor people. We are primarily funded by the Legal Services Corporation in order to provide support and assistance to legal services attorneys throughout the country on legal problems of their elderly clients. In this connection, we work directly with legal services attorneys on behalf of their clients on litigation, legislation, and administrative advocacy.

We are also currently funded by the Administration on Aging as a national support center for legal problems of the elderly. In that capacity, we work directly with legal programs funded under the Older Americans Act, as well as many state and area agencies in aging, legal services developers and nursing home ombudsmen with regard to legal issues affecting the elderly throughout the United States.

The work of the attorneys at the National Senior Citizens Law Center, as our many experiences with this committee have demonstrated, covers a myriad of areas of the law that affect elderly people. We have, however, since the beginning of our program placed special emphasis on the mental health problems facing the elderly, particularly with regard to guardianship/conservatorship programs, protective services issues, and public guardianship issues. One of our former attorneys who has specialized in this issue, Peter Horstman, has written one of the seminal law review articles on this subject and both of us have had a long history of working with elderly people who have been the subject of numerous guardianship and protective services mechanisms in various parts of the United States.

We believe that our office has a unique perspective on the issues of physical and economic abuse which are the subjects of today's hearings before the committee. We not only are in a position to have discussed these issues with attorneys, state officials, aging organizations, and legislators, but more importantly, we have viewed these problems from the perspective of the elderly person who is the subject of the alleged abuse. Our office, and our constituent legal services and Older Americans Act attorneys, have represented people who have been dragged through the various guardianship and protective services programs that are being advocated as solutions to the abuse problem. We believe, therefore, that our experience will aid this committee in its deliberations and offer some insight into the limitations of government programs to combat abuse problems.

The issues surrounding physical and economic abuse of the elderly involve social, moral and legal issues of the highest order. It is, of course, impossible in a short period of time to extensively cover all of the aspects of this problem. Today, we would like to concentrate our testimony on two issues.

First, we will provide the committee some of our general views on the civil rights and civil liberties issues which are raised by the various solutions to the elderly abuse problem that have been proposed. Unfortunately, in our experience in discussing and working on these issues, many people with the best of intentions have neglected to consider the constitutional and civil rights violations resulting from their actions. We must not lose sight of the fact that the persons about whom we are talking today are adult citizens of the United States possessing all of the rights of citizenship and you and I. They have the same right to be free of unwanted government intrusion as do any other citizens.

Second, our testimony will focus on one particular aspect of economic abuse of the elderly—economic abuse by the federal government. We raise this issue today for two reasons. One, we believe that it has been an area long overdue for analysis and review by Congress. Second, as opposed to many of the other abuse issues which largely fall within the province of state and local governments, economic abuse by the federal government is totally within the control of Congress. Consequently, this is an area which you can affect directly and immediately.

I. PROTECTING THE CIVIL RIGHTS AND LIBERTIES OF THE ELDERLY

A fundamental principle of our form of government, which is, of course, enacted in our Bill of Rights, is the fact that every citizen is entitled to protection from unwarranted and unwanted government intrusion in their lives. We have been loath to sanction forceful government action and in fact, outside of the criminal law context, it occurs rarely, if at all, in our legal system. There is, if you will, a fundamental constitutional right of people to be left alone, as long as they do not violate our criminal laws.

These issues are raised in the physical and financial abuse area by the solutions that are proposed to the problem. Certainly, we do not condone in any way physical or financial abuse of any persons, including the elderly. On the other hand, even if that abuse occurs, we must remember in proposing solutions that the answer cannot merely be involuntarily imposing government upon the alleged abused person. The consequences of that government intrusion can indeed be great.

As an example, which is drawn from our experience, will help illustrate our point. A neighbor may report that Ms. A appears to be incoherent, has some bruises, is heard moaning, and Ms. A's daughter has been heard screaming and yelling at Ms. A. That report is made to appropriate local officials who send out a protective services worker to investigate. The protective services worker forces him or herself into Ms. A's home, talks to her, and decides that indeed Ms. A has been abused and that it is not in her interest (according to the worker) to remain in her home as that will have detrimental physical and emotional effects. The worker asks Ms. A if she is willing to leave the home and Ms. A refuses, noting that she really does love her daughter and would under all circumstances prefer to live in her present home. Nevertheless, the worker feels Ms. A cannot make a rational judgment and under the authority of state protective services and reporting laws determines that Ms. A must be immediately removed from her home and proceeds to take the necessary actions to produce that result. Ms. A very quickly against her will ends up in a nursing home, becomes very depressed and withdrawn as a result of her involuntary incarceration in the nursing home, quickly goes downhill and dies wihin a short period of time.

We wish that we could say that this example is unusual. Our experience shows it is not. It illustrates for this committee how, under the guise of helping someone, government intervention can produce disastrous results. It further illustrates that the rights of the elderly person are in many, if not most, cases ignored in the process of determining what is best for that person. Elderly people are not children. They maintain, in the eyes of the law, the civil rights and liberties of any other adult citizens of this country, and they must be treated accordingly.

In studying and proposing possible solutions to aid and help with problems of physical and financial abuse of the elderly, we urge this committee to be extremely wary of programs and statutes which do not provide inherent protections of the rights of the elderly person. We believe no services ought to be provided on an involuntary basis, unless the elderly person has been found incompetent under the appropriate guardianship or conservatorship statutes, to make decisions for him or herself. Further, only a guardianship statute which fully and adequately protects the constitutional due process rights of the person is sufficient for a determination of incompetency. In fact, the President's Commission on Mental Health specifically made such recommendation a few years ago.

We do not support protective services laws or abuse reporting laws which provide for involuntary services outside of the guardianship/conservatorship mechanism. We believe an adequate, well drafted, and constitutional guardianship/conservatorship statute provides a sufficient mechanism under our constitutional system to provide necessary services. We must recognize that those people who are service providers cannot always substitute their judgment of what is in the best interest of a person for that person's own judgment. Our Constitution protects the right of our adult citizens, including our elderly, to make their own judgments, except possibly when they are found to be incompetent to make those judgments. We cannot have protective services laws or reporting laws which try to evade guardianship programs which ignore due process of law protections under the guise of helping people. One recent protective services and reporting statute which we believe comes very close to our views is that adopted in the State of Missouri last year. That law calls for reporting but does not allow for involving protective services unless the person has been brought to court through the guardianship procedures.

Similarly, we believe this committee ought to be extremely wary of support of any public guardianship program. We in California, as Representative Burton is well aware, have had a fairly lengthy experience with the public guardian system. We wish we could tell you that the system works; unfortunately, our view is that it does not.

In our judgment, the public guardian system as it has been used in most areas of California results in extreme over and unnecessary institutionalization of other persons. We have, in fact, filed suit on various occasions against the Los Angeles County Public Guardian's office on this very point. It is our view that if you have a public guardian, you can be sure within an extremely short period of time that you will be in a nursing home and that, in our view, is the beginning of the end for the elderly.

Public guardians are not a panacea. They may in fact do significantly more harm than good and need to be extensively analyzed and evaluated before they are supported as an answer to the abuse problem. Questions need to be asked, not just about how the public guardian handles an extremely incoherent and incompetent person with medical problems, but also about how the public guardian handles someone who merely wants to be left alone and does not live in an environment that some people think is in their best interest. Are those latter people going to be harmed or helped by a public guardian putting them in a nursing home? Each of us may have different views of the answer to that question but none of us knows for sure, as public guardians are a recent phenomena whose impact has not as yet been adequately measured.

Thus, for us, the recent issues that have been discussed in the newspapers in San Francisco concerning the fact that the public guardian does not accept as wards persons with incomes below a specific amount is not an issue of whether or not income guidelines are appropriate. Instead, the real issue is whether those poor people are better off without public guardians than with them. We believe it is encumbent upon the aging community, this committee, and those people who are proponents of public guardians to demonstrate the benefits before they impose that system upon the elderly.

This committee must remember that legally what happens when a person receives a public guardian is that a person's civil rights and liberties have been granted to the state for the state to exercise on their behalf. We can think of no other law in our constitutional system that gives over a person's civil liberties and rights to the government. If we are going to let that happen, we must be extremely vigilant in viewing that kind of system and must assure that constitutional rights are protected in the exercise of that system.

II. FINANCIAL ABUSE OF THE ELDERLY BY THE FEDERAL GOVERNMENT

We believe that one important aspect of financial abuse of the elderly has been ignored by most of the various studies and commentators on this subject. That issue is the abuse perpetrated on the elderly by the Federal Government's representative payee systems.

Most of the Federal benefit programs and in particular Social Security and Supplemental Security Income (SSI) statutorily provide that the agency may unilaterally determine that a person is not capable of handling their own funds. As a result, the agency will appoint a representative payee who is another person, organization, or agency who is to receive the government benefit and spend it on behalf of the recipient.

There are, of course, serious constitutional issues about the mechanism by which representative payees are appointed. There are also serious statutory and constitutional issues about the ability of various organizations and agencies, such as a nursing home where the recipient resides, becoming representative payees. We will not discuss those problems today but by glossing over them, we do not mean to suggest they are not serious and ought to be of great concern to this committee.

What we would like to concentrate on today, however, is the Federal Government and in particular the Social Security Administration's failure to control and police the representative payee system. Frankly, what our experience and our clients have shown is that the Federal Government hands out millions, indeed perhaps billions, of dollars to representative payees and has (1) no idea what happens to that money, and (2) even when they do find out, tries to wash their hands of it and not to protect the elderly recipient.

We have firsthand knowledge and information about this subject, as we represent a nationwide class of recipients who have had representative payees in a suit now pending in Oklahoma. That case is *Jordan* v. *Harris*, No. 79-994T (W.D.Okla). The suit raises serious and important questions about the fact that the Social Security Administration has in the past unilaterally decided to halt all accounting of representative payees. By that action, the government directly condones, in our view, financial abuse of the elderly, SSI and Social Security recipients who are on the representative payee system. How are those recipients going to protect themselves against abuse by payees when the agency that gives out the money closes its eyes as soon as it signs the checks?

The payee system allows for enormous fraud and abuse. For example, there were many reports that the Rev. Jim Jones received thousands of dollars monthly directly to him as representative payee for persons in his camp in Guyana. How was Rev. Jones able to become payee for so many people? Why did the government never, as far as we know, audit Rev. Jones' expenditures of the Social Security and SSI dollars he received?

In addition, even if SSA were to audit and take some control over how the payee spends dollars, there is another question that must be answered. The second question is, if an abuse occurs, how can it be remedied?

SSA takes the position, which in fact they have clarified in recent proposed regulations, that when an abuse is discovered, there is no government liability or no government involvement. In other words, the elderly person whom SSA has already determined is unable to care for his or her own financial means is left to his or her own devices for a remedy. We are then left with an older person having to discover on their own that their payee is misspending dollars and then to find a mechanism on their own to remedy the situation. They receive no help, no assistance, no advice, no responsibility from the Social Security Administration who administers the benefit programs.

We believe that this representative payee system, as run by the Social Security Administration and as apparently authorized by Congress, encourages financial abuse of the elderly. We believe that if Congress cannot assure that its basic benefit programs for the elderly are not used to financially abuse them, then Congress cannot insert itself in private relationships that may result in financial abuse. We urge this committee to begin a full and complete investigation of the representative payee system of the Social Security Administration. Such a study should attempt to clarify the fraud and abuse which we believe is rampant in that system and to propose clear and distinct protections for the benefit recipients that will make the Social Security Administration accountable for its errors and will allow the elderly to in fact receive the benefits for which they are entitled.

Of course, our office would be more than happy to work with the committee on such a study and to aid them in drafting legislation that will prohibit this financial abuse of the elderly by the federal government in the future. We will continue our fight through the courts to remedy this enormous problem, but it would be far better, we believe, if Congress would attempt to tackle this problem and resolve it affirmatively by appropriate legislation.

We hope that this testimony will prove useful to the committee in its consideration of the issues of physical and financial abuse of the elderly. In closing, we would like to remind the committee of the comments of U.S. Supreme Court Justice Louis Brandeis more than 50 years ago: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficient. . . . The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well meaning, but without understanding." *Olmstead* v. *United States*, 277 U.S. 479 (1928) (Brandeis, J., dissenting)

Ms. Oakar. Thank you, Mr. Chiplin.

Mr. Gilfix.

STATEMENT OF MIKE GILFIX, DIRECTOR, SENIOR ADULTS LEGAL ASSISTANCE, PALO ALTO, CALIF.

Mr. Gilfix. Thank you. I would also like to thank you for the opportunity to present my views, both here and in written testimony.

I would also like to present some brief personal background. I have been director of a legal services program serving elders for over 7 years. In this capacity, I have had the good fortune to have been involved both in individual cases in the community and in the development and pursuance of legislation and regulations at the national level.

I would like to address the problem of elder abuse from two perspectives. The first is the broader of the two and, I believe, the most important. It is my grave concern when I see our society respond to problems like this by focusing on the crisis. Our response in such circumstances tends to be visceral, emotional, and myopic.

I am concerned when we focus on gross physical abuse cases and want, above all, to punish the perpetrator. Such a response is after the fact and does not help individuals who have been abused.

I must say that I strongly disagree with the implicit suggestion by California Assemblyman Felando that life imprisonment as a punitive approach is the solution to this kind of problem.

We have to realize that over 70 percent of the abusers are family members. This makes the problem much more complicated and raises serious questions about a punitive type of approach. We have, instead, to look at the causes of elder abuse: economic stress; the fact that so many of the abusers have mental, psychological, alcohol, drug problems. These factors—the real cause of abuse— can be addressed only by looking to more basic societal factors that are unavoidably included in the equation.

We have to think about spousal abuse. We have to think about child abuse. We must acknowledge the close relationship of these phenomena to elder abuse and address them at the same time.

If we are, in other words, to productively address the problem we must adopt a preventive strategy and look at the roof causes.

The conclusion, I suppose, is obvious at this point. I am calling upon each of you to increase your vigilance in Washington. I am calling upon each of you to realize that the Oakar-Pepper bill, as good as it is, is not a solution if it must stand alone as other relevant programs are slashed to nonexistence.

For example, we see radical cuts in funding that would result in the elimination of many of the staff members that you saw here with victims today. Consider Mrs. B, who testified earlier. The legal worker from our office, Ms. Lucy Fitzpatrick, who brought her here today and who is helping Mrs. B is a VISTA volunteer being paid the outrageous salary of $3,500 a year. That program is scheduled by the Reagan administration for expiration in 1983.

A minimal amount of Federal money is doing an incredible amount of good.

My second, more specific comment relates to the Oakar-Pepper bill, which I strongly support. It focuses on financial, rather than physical abuse, and raises ethical questions for key service providers who are asked or told to report cases of abuse to an outside authority. I am worried that this legislation presumes away some of the most serious problems in this context.

In presenting my recommendation, I would like to focus on lawyers, because I am a lawyer and that is the profession that I know best.

Congressman Lantos earlier suggested that some attorneys will join their clients in unscrupulous acts to take advantage of older persons. I suggest that it is not always an unscrupulous lawyer. I think it is often a typical lawyer, somewhat amoral, looking exclusively at his or her client's needs in instances where the conservator or guardian is the client. In most such cases, the attorney is not looking at the impact of a conservatorship, or of actions of the conservator, on the real party in interest, the conservatee.

The lawyer's canons of ethics are relevant to this discussion. They are designed to protect the lawyer as well as the lawyer-client relationship. Of the most time honored is the proscription against revealing any information obtained in the confidential lawyer-client relationship. Its implications for mandatory reporting are obvious.

The question I raise, then, is: Where is the critical link in financial abuse cases of which we are aware? In many cases, that critical link is made by the attorney. Analogously, I refer you to legislation now requiring physicians to report cases of venereal disease to health officials. The reasoning is clear: physicians are uniquely in a position to discover the problem and, therefore, must be compelled to report it if it is to be controlled. When it comes to child abuse, we also look at those who will discover it. As indicated, attorneys are often the only ones who are going to discover financial abuse.

In the context of conservatorships, it is obvious that an attorney representing the conservator must be involved in or become aware of manipulation of the conservatee's assets.

In nonconservatorship cases, attorneys may advise the use of and prepare powers of attorney that can be as complete as a conservatorship in conveying control of an elder's assets to a friend or relative. In our work, we have also seen living trusts, deeds of conveyance, and other legal documents—all prepared by attorneys—that convey an elder's property, or control of such property, to another. Please see case histories in my written testimony.

Is a particular elder being financially exploited by another? In a great many cases, only your lawyer knows for sure.

What I would like to recommend in support of the Oakar-Pepper bill is that we liberalize the confidentiality rules. Attorneys in some cases might be compelled to reveal confidences or at least allowed to do so in cases where they feel they must do so.

Right now they are actually prohibited from doing so. If they object to what a client wants to do, they can withdraw from the case, and say no more. I think that is wrong.

There is precedent for my recommendation. The American Bar Association has appointed the Kutak commission which has recommended many changes in the canons of ethics of the ABA. The canons of ABA are adopted wholesale in over 40 States, so you see their significance.

In proposed Rule 1.7, they address precisely this point of confidentiality. They are recommending that in some cases a lawyer shall disclose information when it appears necessary to prevent the client from committing an act that would result in death or serious bodily harm to another person, or in some other limited circumstances.

Subpart C (2) says that a lawyer may disclose information about a client to the extent that it appears necessary to prevent or rectify the consequences of a deliberately wrongful act by the client. This represents a radical departure from tradition.

It is most significant that an American Bar Association commission has recommended this departure. There is, then precedent for my recommendation. The commission is relying on a development that argues for a change. It is in the form of two cases. The first, *Tarrasoff* v. *Regents of California*, involved a psychiatrist whose patient revealed an intention to kill someone. The patient did so, and the psychiatrist was successfully sued by the victim's relatives.

In *In Re Four Seasons Litigation*, a law firm was held liable in a stock fraud case, because they knew what was going on and they did not do anything to prevent it. Four Seasons is, in my view, precisely on point and argues compellingly for my recommendation.

We must acknowledge, in other words, that some values must transcend that holy of holies, the inviolability of the attorney-client relationship.

In conclusion, I again stress the need for approaching the problem of elder abuse as a systemic, societal problem with multiple causes demanding multiple responses. We must not respond only after it has happened.

[The prepared statement of Mr. Gilfix follows:]

PREPARED STATEMENT OF MICHAEL GILFIX, DIRECTOR, SENIOR ADULTS LEGAL ASSISTANCE, PALO ALTO, CALIF.

I am pleased to have this opportunity to present testimony on the subject of elder abuse. Unfortunately, I have encountered examples of such abuse on numerous occasions in the delivery of direct services in Santa Clara County, California. I have also encountered it as a statewide and nationwide problem in addressing both legislation and regulations pertaining to long-term care.

Indeed, Senior Adults Legal Assistance (SALA), which maintains offices in San Jose, Gilroy, and Palo Alto, California, has grown increasingly concerned about this problem over the past year. We have been involved—often in cooperation with other service agencies—in preventing financial abuse by an elder's closest relative. In too many cases, we were contacted after the damage was irrevocably done. To illustrate cases of financial abuse of elders, I will now present brief summaries of cases we recently encountered in our office.

The case of Mrs. B

Mrs. B is an eighty year old woman who was victimized by her only relative, her nephew. Her health is quite good and she is competent. Her primary language is Italian, although she can communicate in English.

After a short absence from her home in San Jose, California, for medical reasons, she returned to find an empty house. Her household possessions were literally sold out from underneath her. Her immediate reaction to this discovery was depression, shock, and resignation. For the next two days she sat in her home, neither eating nor communicating with anyone.

She was in the habit of eating lunch at the Sears store across the street. Sears' employees became concerned about her failure to come in and contacted the police. The police found her at home and contacted her only known relative, her nephew. They did not know that the nephew was responsible for the sale of her possessions.

When discovered, she was suffering from malnutrition and needed medical attention.

At the urging of her nephew, she signed a voluntary consent to a conservatorship and signed an admission contract to a nursing home. There remains serious doubt about whether she understood what she was signing. Parenthetically, Mrs. B now refuses to sign any document unless it is offered to her by a SALA worker or another service worker in Santa Clara County whom she has come to trust.

Fortunately, a housekeeper in the nursing home spoke Italian and became friendly with Mrs. B. The housekeeper contacted the nursing home ombudsman volunteer who, in turn, contacted our office. After assessing the facts, our staff took the following actions:

1. brought the Public Defender's office into the case to have the conservatorship terminated;
2. evicted the tenants who were placed in the home by, and making all the payments to, the nephew;
3. obtained the early release of some conservatorship funds so that her home could be prepared for her return;
4. represented Mrs. B in court at a final accounting of the conservatorship and convinced the court to disallow thousands of dollars of costs that were claimed by the conservator, the nephew;
5. drafted a Will to insure that the nephew will receive no funds as the sole heir to Mrs. B's estate;
6. worked with the Independent Aging Program of San Jose to remove the nephew's name as representative payee for her Social Security checks.

The case of Mrs. O

Mrs. O is in her seventies and was victimized by her daughter.

Several months ago, she suffered a heart attack. While recuperating—in an apparent "state of confusion"—she was convinced by her daughter to sign a document which was a power of attorney. Mrs. O does not remember signing this document.

Soon thereafter, her daughter withdrew almost all of her life savings from her bank accounts—almost $4,000—and took possession of her car. The daughter later sold or otherwise misappropriated all of Mrs. O's possessions, including furniture, clothing and (of greatest value to Mrs. O) heirloom jewelry and family photographs.

Mrs. O has asked SALA to help her regain her car, her money, and all possessions that have not yet been sold by the daughter. Litigation based on fraud and conversion are clearly available, as are actions in equity to have possessions returned to Mrs. O. SALA is contacting the Department of Motor Vehicles to insure that any accidents caused by Mrs. O's daughter do not become the responsibility of Mrs. O, the owner of the car.

The difficulties inherent in a mother suing a daughter are obvious. There are very real fears of physical retaliation since the daughter has hit Mrs. O on one or two occasions in the past. There is some evidence that the daughter has mental and alcohol problems, which further complicate the situation. Another very practical point is that the daughter is financially irresponsible and has likely dissipated all funds.

The case of Mrs. M

Mrs. M is eighty years old and is apparently being victimized by a "friend" she met at church.

She contacted SALA because she became confused when her "friend" told her that she could live in her house until she died, but that he would get it at that time. Upon investigation, we discovered that Mrs. M conveyed the house to her "friend"—apparently without compensation—and that the "friend" then conveyed back to her a life estate. Mrs. M does not recall this transaction. Unfortunately, her memory is very poor and she is often confused. She is clearly susceptible to trickery and fraud.

The "friend" has also induced Mrs. M to place his name on all bank accounts and her car registration. He now has complete control of her funds and limited stocks.

Mrs. M's questionable legal competency substantially complicates the case. For example, she may not be able to represent herself in litigation and a conservatorship action may have to precede litigation. The "friend" will undoubtedly learn of such developments and, we fear, will seek to liquidate or otherwise abscond with all assets. While the filing of a *lis pendens* would be a likely course, it is a further complicating factor when there can be no certainty that the "friend" has, in fact, taken advantage.

While many conclusions can be drawn from these case histories, I at this point emphasize the utilization of legal documents and the legal system by those who financially abused their elders.

ASSESSMENT AND RECOMMENDATIONS

I would first like to express my support for H.R. 769, The Prevention, Identification, and Treatment of Elder Abuse Act that was recently introduced by Representatives Oakar and Pepper. As in all legislation, there are some problems, but the concept and approach are both timely and sound. Later in this testimony, I will address myself in depth to one aspect of this legislation.

In the balance of my testimony, I would like to address the problem first from the broadest possible perspective and then in very specific terms.

SYSTEM-WIDE RESPONSE

The subject of "elder abuse" is receiving increased attention in the media and the legislature. It is described as a new "national crisis" which demands immediate attention. My concern is that, in reacting to a crisis, we will focus only on the most physical aspects and react viscerally, such as by demanding serious punishment for abusers. Aside from the fact that the overwhelming majority abusers are close family members and the psychological implications of punitive measures taken against them, research data and logic compel the conclusion that the causes are complicated, multi-faceted, and in need of comprehensive attack. In other words, causative factors must be addressed. Doing so is less politically popular, less visible, and far more costly. We must ask, however, how serious we are about eliminating elder abuse and what price has to be placed on the security and dignity of our older citizens.

Data presented at these hearings and in the report of this Committee on the issue of elder abuse identify the causes of abuse. They include economic stress on a family that is supporting an older person, the myriad psychological and physical needs of elders that must be addressed by untrained family members who may or may not have time and energy, abusers with histories of mental, alcohol, and drug problems, families with a consistent history of abuse toward children and spouses.

All of us, and members of Congress in particular, must increase our vigilance and realize that impending cuts in social and human services can only exacerbate this problem and insure its growth. We must ask what impact the emaciation or elimination of in-home support services, nursing home regulatory controls, legal services, senior day care services, and others will have on the problem.

On another level, I am concerned that the increasing exposure of the problem will heighten expectation on the part of abused elders and the community at large. We must ask: what good are we doing if we expose the problem and do not have community resources that can address them? The proposed Elder Abuse Act would require specialized facilities and procedures to address these problems. This might be the most significant provision of this legislation.

ETHICAL ISSUES IN MANDATORY (OR VOLUNTARY) REPORTING

H.R. 769 provides for the mandatory reporting of both known and suspected cases of elder abuse, neglect, and exploitation. Without question, this requirement is a cornerstone of the Act. It is also a requirement that raises many serious questions without answering them.

Not the least of these questions involves the ethical and, in some cases, legal implications of compelling a professional to reveal confidential information. This can be particularly problematic in cases of financial abuse, which is the focus of this testimony.

Parenthetically, note that physical abuse is a) more visible, and, therefore, easier to detect, and b) most often revealed to the medical profession, which has faced mandatory reporting issues in the contexts of child abuse and venereal disease. The reporting requirement in H.R. 769 opens an entirely new professional and ethical frontier as it relates to financial abuse. This fact may have been overlooked or, at least, under-emphasized in drafting this legislation because cases of physical abuse most readily come to mind and are more clearly documented.

My concern, then, is with the viability of the mandatory reporting requirement, particularly as it pertains to attorneys and other professionals who may encounter incidents of financial exploitation.

FOCUS ON ATTORNEYS

In fact, current state legislation is entirely inconsistent with the mandatory reporting provision as it pertains to attorneys. California's approach is typical of virtually every state. Section 6068(e) of the California Business and Professions Code requires an attorney "to maintain inviolate the confidence, and at every peril to himself to preserve the secrets of his clients."

California is typical in that almost every state has adopted the Code of Ethics of the American Bar Association by incorporating it into state law.

Before suggesting how to resolve this conflict, I again emphasize the need to include attorneys in the mandatory reporting provision. Without doing so, most cases of financial abuse will not be discovered.

The critical point bears emphasis: attorney are often the critical, vital link in these cases. They prepare the legal documents or give the legal advice that enables the abuser—who is also the attorney's client—to engage in conduct that takes advantage of an older relative or friend.

Consider the three examples presented at the beginning of this testimony. In the case of Mrs. B, an attorney prepared all documents pertaining to the supposedly "voluntary" conservatorship. That same attorney also prepared a lease for the rental of Mrs. B's home and helped the nephew, his client, prepare the final accounting of the conservatorship.

An attorney prepared the power of attorney that enabled Mrs. B's daughter to abscond with all of her funds. An attorney prepared the deed and life estate document that resulted in the loss of Mrs. B's home to a "friend."

In each case, the attorney's client was the abuser. It is highly unlikely that any of these attorneys considered the implications of their work for the older persons involved. Thus the importance of educating the private bar about the problem and then eliminating any barriers to their involvement is a preventive force.

KUTAK COMMISSION

Fortunately, my recommendation has already been incorporated in Model Rules of Professional Conduct, which were prepared by the Commission on Evaluation of Professional Standards (best known as the "Kutak Commission"). Published on January 30, 1980, these proposed Rules are not yet adopted. They propose many major changes in the Code of Professional Responsibility, which is also referred to as the Code of Ethics.

Proposed Rule 1.7 provides, in pertinent part:

(b) A lawyer shall disclose information about a client to the extent it appears necessary to prevent the client from committing an act that would result in death or serious bodily harm to another person, and to the extent required by law or the rules of professional conduct.

(c) A lawyer may disclose information about a client only:

> (2) To the extent it appears necessary to prevent or rectify the consequences of a deliberately wrongful act by the client, except when the lawyer has been employed after the commission of such an act to represent the client concerning the act or its consequences;

These recommendations represent a radical and, I believe, needed change in rules pertaining to the confidentiality of attorney-client communications. In instances where, for example, an attorney learns that her client desires legal assistance in gaining control of a frail elder's estate for personal reasons, it is not enough to simply withdraw from the case. That client will either find a willing attorney (perhaps by veiling motives in the next interview) or another means of achieving exploitation. Unless that attorney informs an appropriate authority of the threat to an elder's assets (and independence), no one will.

The reason: no one else will know.

SPECIFIC RECOMMENDATION

My specific recommendation is that the Committee and its staff:

1. research and assess the conflictory implication of reporting requirements in H.R. 769 and of state law, which prohibits such reporting by attorneys;
2. express its support for and work with the ABA Kutak Commission to have ABA Rules of Professional Conduct modified by adopting proposed Rule 1.7; and
3. communicate and work with state legislatures and state bar associations to ensure adoption of proposed Rule 1.7 into state law.

Ms. OAKAR. You are talking about preventive types of things. And I think that is an incredibly broad statement.

Mr. GILFIX. It is indeed, and necessarily so. In closing, I would also like to reiterate that you must give real consideration to modifying an unnecessary absolute constraint currently placed on attorneys, social workers, and other professionals who are dealing with this problem on a day-to-day basis.

Thank you.

Ms. OAKAR. Thank you very much. That was very thoughtful testimony.

Mr. Feder.

STATEMENT OF BRUCE A. FEDER, MANAGING ATTORNEY, LEGAL ASSISTANCE TO THE ELDERLY, INC., SAN FRANCISCO, CALIF.

Mr. FEDER. My name is Bruce Feder.

I am the managing attorney of Legal Assistance for the Elderly here in San Francisco.

We are in a law office for senior citizens in San Francisco. We currently have 7 attorneys in our office but we do stand to lose about 75 percent of our service in the next year.

I would like to review my comments which will only take a few minutes. And then I would welcome any questions that the committee might have.

During the past 2 years, our office has received an increasing number of requests for assistance with regard to physical or financial abuse of elderly persons. These requests come primarily from friends, relatives, social workers, or sometimes the abused victims, themselves.

The abusor might be anybody's son, daughter, spouse, just a friend, brother, sister, nurse, or government employee. More often than not, the victim is a woman and too often the victim is either too confused, too intimated, or too isolated to seek appropriate assistance.

Mrs. Smith, whose real name I cannot reveal, is a 60-year-old woman who has been married for 10 years. Although she owns the house in which they live, the Smith's only income is Mr. Smith's pension of over $1,200 per month.

Mrs. Smith is a few years older than Mr. Smith and he drinks away a significant portion of his monthly check. And he drinks heavily and routinely abuses Mrs. Smith both verbally and emotionally and occasionally he physically beats her. Even when he does not actually strike her, the constant threat of being battered at any time is terrifying. Occasional intervention by police has proven to be short-term, temporary relief, at best.

When the police leave, the source of the problem still exists and Mr. Smith is angrier. Mrs. Smith would have left her husband years ago if she had had either income of her own or some other source of support which would have helped her to pay the mortgage on her home and purchase the daily necessaries of life.

Mrs. Smith's story is, indeed, an unfortunate one. And she would be here today, herself, to tell her story were she not fearful of retaliation by her husband.

Mrs. Smith's story demonstrates only one aspect of that which can occur in a variety of circumstances and which can manifest itself in numerous ways.

We have worked with older persons who are literally held captive in their own bedrooms by their own adult children. We have assisted older persons who are being financially abused by their conservators. We have represented older bedridden persons who are left without assistance by their younger spouses.

We have encountered several cases where elderly people have had their life savings or their homes taken away from them by dishonest or older reaching children, their adult children.

There are various legal remedies which are of some assistance when dealing with the problem of elderly abuse. Most of those legal options provide some relief for a problem, then, rather than solving or getting a solution to the problem, itself, or a method by which the source of such problems can be altogether avoided or eradicated.

There are other people here who have had or spent substantial amounts of time studying possible solutions to elderly abuse, and they would, therefore, be more qualified to describe to you their specific ideas for potential solutions.

I do have some general suggestions based on our experiences in working with the elderly, which are perhaps appropriate for congressional consideration.

It is important for people such as Mrs. Smith, who I previously mentioned, to have access to appropriate temporary shelters to so escape the physical and emotional abuse which threatens them at home.

Such shelters should provide the public assistance and counseling that may help to lead to a resolution of the problem.

It is also important for local law enforcement agencies to have the funding to acquire and train special staff who can effectively deal with problems involving elderly abuse.

Further, I believe that some elderly people are generally in need of someone to handle their affairs, but conservatorships and guardianships are overused and often imposed or impose unnecessary restrictions on an elderly person's power to make his or her own decisions.

Agencies, both public and private, nonprofit, which provide financial and personal management services for elderly persons should emphasize a need to assist people in a manner which is least restrictive of their personal liberty and which maximizes their ability to live independently.

An additional manner in which elderly persons can be encouraged to continue living in an independent setting is the adequate provision of comprehensive day care centers where older people can receive their various health, recreational and social services that are needed.

Too often an adult child that shares a home with an elderly person cannot provide the many hours of daily care that the parent may require. Frequently, the unfortunate result is that the child, out of frustration, either physically abuses or inappropriately institutionalizes the parent due to an unwillingness to continue providing the necessary care.

It seems likely that the availability of day care centers and respite care which would enable the caretaker to temporarily get away from the caretaking responsibilities will help avoid many instances of elderly abuse.

Serious consideration should also be given to the establishment of reporting laws which are required and a person is likely to encounter to report any such instances to the appropriate agency.

Perhaps this would assist those victims who are afraid or are too confused to know when to go for help or those who have not sought assistance because of the emotional upset which accompanies the process of reporting to a stranger that a member of one's own family is guilty of abuse.

Finally, I would urge the Congress to continue to grapple with the physical and emotional abuse that too often occurs in the nursing homes, keeping in mind that the profit motive inherent in the private nursing home industry and its effect on the relatively helpless patients who are often institutionalized against their own wishes.

Abuse of elderly persons is an all too common occurrence, the prevention of which will require comprehensive planning. It is imperative that the entire problem be brought before the public eye and that the public be educated as to its widespread existence and the need to coordinate our efforts.

Thank you for the opportunity to present the testimony.

Ms. OAKAR. Thank you, Mr. Feder.

I want to thank the panel. I do not have questions, but I would like to make a very brief statement.

I notice that both Mr. Chiplin and Mr. Gilfix centered around an isolated piece of legislation in terms of it being the end-all to end this terrible problem. I can assure you that on behalf of Congressman Pepper and myself, who are the major sponsors of our elder abuse bill, that we really agree with you that we need emergency shelters, respite care, day care, home health care, tax incentives for the families, which would perhaps relieve some of their financial stress, some kind of home rehabilitation, maybe a low-interest-loan program to provide for their having an area in the home to help them stay, certainly counseling which is provided for in the bill for those who did the abusing. They obvously need some help.

We are very disturbed by some of the proposed cuts at this point that are being made, as is my good friend and colleague, Congressman Lantos, also.

Now we respect your helpful suggestions also about the legislation.

Congressman, do you have a point to make?

Mr. LANTOS. Just a couple of minutes.

I would like to recognize Ms. Janet Levy who has headed up our State program for years with great distinction in this area.

I have one question which relates to the impact that the elimination of legal aid to the poor would do to these kinds of efforts. May I have a very brief response from each of you, gentlemen?

Mr. Alexander.

Mr. ALEXANDER. I have really been concentrating this morning on aspects of help for the elderly that do not require Federal funding. That is obviously unaffected.

I certainly believe that some of the cuts that I proposed are going to have a very serious effect, but the brunt of my concern at the moment is to find ways of doing the sorts of things that are necessary without financial help.

Mr. LANTOS. Right.

Mr. CHIPLIN. As I said earlier, I am with the National Senior Citizens Law Center in Los Angeles. It is a federally funded legal services program that provides legal assistance to the legal services community and also to senior citizens' advocacy groups funded through the Administration on Aging of the Department of Health and Human Services.

In general, legal services to the elderly will cease to exist. This is particularly alarming in regard to people who are in situations of confinement. They will lose an important means of protecting their rights.

There is little likelihood of help from the private bar. It will not be interested in these cases unless there is possibility of a meaningful fee.

If there is a cutback in legal services funding, it is very likely that the backup centers will be one of the first groups of services to be deleted.

That will have a tremendous and detrimental impact on the entire legal services community. We distribute a wealth of information to program attorneys and to groups like the Gray Panthers, to legislatures around the country and the like.

We also do significant impact litigation on all types of matters. We have been involved in the whole area of looking at protective services laws and the problem of representative payee for many years. I think if our services are cut out that there will be a tremendous shortfall in the ability of the individuals to obtain the kinds of services that they need, as often, we are in situations where you need an adversarial relationship in terms of attorneys on every side of an issue so that people can be heard.

More often than not, the kinds of abuse issues that come up are not necessarily attractive cases to the private bar, so you will often find that the abused elderly as well as other significant groups in a community just will not be able to engage in this adversarial process.

Mr. LANTOS. I thank you very much.

Mr. Gilfix.

Mr. GILFIX. My first response is to ask, who else? In the context of elder abuse, for example, 99 percent of the legal workers representing abused elders are funded either by the Legal Services Corporation or by the Older Americans Act. Significantly, title III of the Older Americans Act does not mandate legal services. At this time, our program and many others are funded by title III.

Moreover, private attorneys have neither the capacity nor desire to do outreach in the elder community, as our programs do. If we do not go into the nursing homes and if we do not go into senior day care programs and tell them what we are doing, and tell them what alternatives there are, they are simply not going to know what their legal recourse is in various situations.

And, being very realistic, there are rarely fees in these cases that are commensurate with the work involved. Such cases take an enormous amount of time and necessitate a thorough knowledge of the entire social service network. Private attorneys almost always lack such expertise.

To suggest that legal services needs of disadvantaged persons will somehow be addressed even if public funds are eliminated is naive, at best. At worst, it is unconscionable.

Mr. LANTOS. Mr. Feder.

Mr. FEDER. I don't want to repeat what Mike said. That is pretty much a summary, but I think that it takes offices such as ours to help provide the needs and be most sensitive to the needs of elderly clients. The public bar has, now in my experience, not shown that sensitivity, or the responsiveness.

Perhaps another point that showed be made is that our obligation is to the elderly community and not specifically or only to individual clients, I think that it is important that the elderly have that available.

The bottom line really for the elderly people, it may be best summarized by an ad I saw in a magazine for the Legal Aid Society asking for contributions and it simply said, due to a lack of funding this year, there will be a shortage of justice. And that is what it is going to mean to elderly and poor people in this country, if those cuts are made.

Mr. LANTOS. It is the judgment of this member of Congress that equal justice under the law is not feasible for the abused elderly if these programs are eliminated.

I want to apologize, Madam Chair, but I have another meeting that I have to go to.

Ms. **Oakar**. Thank you and I want to thank you for your hospitality in this area of the country. Both you and Congressman Burton, thank you.

Did you have a question, doctor?

Mr. **Filante**. Madam Chairman, I do have a couple of comments and I really appreciate Congressman Lantos bringing up this point, because I would say that if we were to see some drastic cuts in Federal funding that it could well result in some sort of a disaster, whatever your definition is, unless it was also accompanied by a decrease in inflation so that were not taking away people's wealth and money, unless it was also accompanied by an increase in personal responsibility to individuals and families. And we have not seen that in the last 10 or 20 years; that is, with the various Government programs.

Unless we had an increase in funding of local programs with the tax dollars that might be left over from Federal tax cuts. I think that it is crucial that people get the Federal and local and State level and the private sector to understand their interrelationship, so that no matter which policy direction we take we are prepared.

Along this same line, Mr. Feder mentioned I thought a very important point and that is that, one, we are thinking about the elderly, especially, and the financial cost that we need to take care of and include the ideas such as day care and respite.

We have found in our studies here at the State level which, as I said, involves usually half Federal funded money, that that type of alternative is often less expensive than another one, such as hospitals and it is crucial that we get that through some of the heads of the bureaucrats or whomever, making and imposing these decisions.

We have had to also make many changes in the profession lately and I do not know what the right answer is, but at least it is beyond what I am talking about.

Dean, I apologize for interrupting you before, but you have brought up a good point. I think in your comments you were only looking at the disease trained in a narrow sense. I think that is partly the fault of the medical profession and the teaching professions. It is also partly the fault of the Federal Government that has put the emphasis on Federal funding for research.

I am glad that we are beginning to understand. I would take exception to your statement that a physician cannot interpret and evaluate the factors about how a person can cope or can relate to the various factors in his life environment.

Because of my own personal experience, my wife and I have been family doctors for 30 years, and we remember that. I am an ophthalmologist and she is a specialist in what is called physical medicine and rehabilitation. Her primary job is to do what you say physicians cannot do, and that is to interpret the physical and mental state and evaluate that in relation to the job, home, and family, government, and whatever else is there and to the extent that the services of such physicians are not known or used, you are absolutely correct, but to the extent that we say physicians cannot be doing this, I strongly disagree.

Thank you.

Ms. **Oakar**. Do you want to respond, Dean?

Mr. **Alexander**. Yes.

Thank you very much for the comment. I certainly agree with you that the general training of physicians is in treatment rather than in prognosis of social behavior.

The problem is that much of our legislation, including all of our legislation dealing with involuntary hospitalization and dealing with conservatorship has assumed that there were physicians able to do the sort of thing that you have described adequately for all of those programs.

And the few studies that exist demonstrate that that simply is not true at the moment. Now you believe that it is not true because people have been mistrained because of Federal funding.

I believe it may be untrue because it may be beyond the skills of human beings to predict how other humans are going to behave.

But whichever is true, I think we would agree that it is true at the moment that we don't have the kinds of people on whom we can depend to make the decisions about how others will act in the future. On the assumption that we have such people, we have put away people who were diagnosed suicidal and who, when released, have not committed suicide as dangerous, who when released were harmless and conservatees who, when released have managed their properties very well—despite the fact that they were still diagnosed as harmful or incompetent.

There is extensive literature now that seems to suggest, for whatever reason, that the predictors that we thought we had, simply don't work very well. What we have gotten out of our procedures is tremendous overprediction of dangerousness and incompetence.

When we wanted conservatorships we have found physicians who have testified that it was needed. When we have wanted to institutionalize, we have found physicians willing to do that.

And I think that is not because physicians are bad people, but because the standards are so mushy and medical training so inappropriate that the system will not work.

Ms. **Oakar.** Dean, you do know we have an Ohio law that says conservatorship can be granted on the basis of old age. You say that that ought not be a factor or that somehow we better make sure that we protect the rights of the individual who may be placed under that.

Mr. **Alexander.** I think that it is really terribly offensive for a law to say, as the California conservatorship law said, until it was changed just a few years ago, that one ground for conservatorship is old age. There is absolutely no basis for that.

Grounds for conservatorship, if there are any would be inability to function. That may come with old age and it may come with young age or it may not come at all so that language went out in California. I think it should be out everywhere.

Mr. **Oakar.** We are trying to do that. I know that some of our people in Ohio feel that the age aspect of the law is really very very prejudicial.

Mr. **Filante.** May I just finish a comment.

Ms. **Oakar.** One more comment.

Mr. **Filante.** In answer, I think the dean and I tend to agree on many things. I have never said anyone can predict, but we certainly can evaluate and from the standpoint of experience do many corrective and preventive things. And I think physicians represent only part of the team, I never said that they would be the entire team. To say simply that people are not available is not true.

The fact is that with the misorientation we have had, not laying the blame on anyone or any one place, as you tried to say that I did, I did not lay it only at the feet of the Federal Government.

The point is that there is, to my knowledge as a physician and somebody in the field, an underutilization of this type of person; namely, an understanding trained person. There are also not enough of them but those who are here could be much better used and they are not being used and that is the kind of orientation I am trying to do, rather than to say "they cannot predict." Nobody can accurately predict, but they can use their skills to correct and/or prevent things so let us go out and find them. That is my only point, Madam Chairman. Thank you.

Mr. ALEXANDER. The problem is not the problem of people in the sense of training. The problem is that our society does not trust itself to predict future behavior in criminal law. People walk the streets, because we cannot prove beyond a reasonable doubt that they are guilty.

But people are in institutions when we have only the slightest idea as to what they are going to do in the future. And all I am saying is that the gap between what we are doing and criminal law and what we do in conservatorship is far too great.

Ms. OAKAR. Mr. Chiplin, did you want to make a statement?

Mr. CHIPLIN. Yes. Just one comment on who determines competency or incompetency. It is my feeling that the question of competency should always be a legal one. The courts should determine who is competent and who is not. The role of all of the persons who participate in that decision process, both lawyers, doctors, social workers, and so forth, bring their expertise to bear on the decision but the determination is finally one for the court, either by jury or by the judge. Thank you.

Ms. OAKAR. Thank you.

We know there are some recommendations from the conference and we would like to get them on the record for the benefit of the Members of Congress and so we are going to hear from Ed Villmoare who is the executive director of the National Paralegal Institute, San Francisco.

And Margaret O'Rourke, who is the director of planning, Legal Research and Services for the Elderly, in Boston, Mass.

I would like to thank the members of the legislature for being here also as part of our panel and thank the assemblymen for staying.

Ed, we will hear from you first.

STATEMENT OF EDWIN VILLMOARE, EXECUTIVE DIRECTOR, NATIONAL PARALEGAL INSTITUTE, SAN FRANCISCO, CALIF.

Mr. VILLMOARE. The conference here in San Francisco that preceded this hearing is a companion to the Conference on Elder Abuse and Neglect that was held in Boston last week. The conferences were funded by the Administration on Aging. Their purposes were to explore the current knowledge of elder abuse and neglect and to produce a series of policy recommendations.

What Margaret O'Rourke and I will do is summarize briefly the policy recommendations produced by the San Francisco conference.

One of the major recommendations advanced with near unanimity by the 170 participants, approximately 70 percent of whom have handled elder abuse cases, calls for the training of professionals in the identification and treatment of elder abuse and neglect cases.

In the study by Marilyn Block, over 90 percent of the victims sought help of some form that was not provided by professionals. This data strongly suggests that the professionals failed to recognize the true nature of the problems faced by their clients.

If the needed training is to become a reality, the conference participants believe that funds must be specifically earmarked. The proposed Prevention, Identification, and Treatment of Elder Abuse Act would provide funds for such training. This is one of the reasons why the bill deserves support.

A second major recommendation developed by the participants of this conference calls for a sensitive, concerted effort to build community awareness through public education about the nature of elder abuse.

The conference, this hearing and the media coverage are important first steps; however, each community needs its own education program. The sense of the participants is that such education must be in conjunction with an effort to provide treatment services to those who would be encouraged to come forward and seek help. Otherwise victims may be exposed to greater risk without any real possibility of assistance.

The National Center on Elder Abuse to be created by the proposed legislation could play a major role in such a public education effort.

Now let me turn to more complex matters. The conference addressed two major issues on which no consensus was reached: Mandatory reporting laws and abuse intervention statutes.

For the benefit of the subcommittee, I will outline the principal arguments advanced for and against these two types of statutes.

Those in favor of mandatory reporting laws argue that such laws are now necessary to help determine the nature and extent of the problem. They also argue that many victims, because they are dependent, mentally and physically handicapped, incompetent, or intimidated, cannot or will not seek assistance on their own. They believe such laws will encourage others to seek assistance on behalf of such victims. Evidence shows that the victims frequently do not come forth and the professionals are not reporting the cases.

Those opposed to mandatory reporting laws argue that mandatory reporting must be linked with responsive, coordinated, comprehensive services to avoid stirring false hopes and greater vulnerability. They see little likelihood of such services and, therefore, have reservations about mandatory reporting.

Others are opposed on the grounds that such laws, modeled on child abuse reporting laws, assume that older persons are as dependent and helpless as children and in fact violate the basic constitutional rights to privacy and self determination. They further argue that such laws negate the presumption of competence and alter the traditionally confidential relationship between client and professional. The physician-patient relationship was cited as an example. Under mandatory reporting laws, a physician who suspects abuse would be obligated to report his or her suspicions, regardless of the patient's wishes or even knowledge.

I have only outlined the conflicting arguments. They deserve substantially more consideration than we can give them here today.

With regard to elder abuse intervention laws, similar issues were raised on both sides. Special concern was expressed over the laws of several States on the grounds that they allow intervention in the lives of nonconsenting persons without adequate procedural safeguards or appropriate standards of mental incompetence. Again the issue require much greater attention than time permits today.

I would like to close by offering into the record a manual entitled "Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers," prepared by Legal Research and Services for the Elderly and the National Paralegal Institute. This manual summarizes much of what is known about elder abuse and neglect and explores a number of the issues I have referred to in greater depth.

[See app. 1, p. 57 for material submitted by Mr. Villmoare.]

I now turn the microphone over to Margaret O'Rourke to continue the summary of conference recommendations.

Ms. OAKAR. Thank you, Ed.

STATEMENT OF MARGARET O'ROURKE, DIRECTOR OF PLANNING, LEGAL RESEARCH AND SERVICES FOR THE ELDERLY, BOSTON, MASS.

Ms. O'ROURKE. There is something very challenging about being the last person on an agenda. I feel a little bit like the little red caboose and feel like saying, "I think I can, I think I can," summarize and wrap up without being too repetitive of everything that has already been said.

For the past 2 days, a group of over 120 concerned and sometimes frustrated people have been sharing their knowledge and ideas about the disturbing problem of elder abuse.

The cross section of participants at this conference represents many professions: researchers, doctors, lawyers, nurses, and protective service workers from many of our Western States.

Last week, as you know, a similar group of over 150 persons met in Massachusetts, also to discuss the problem of elder abuse and develop recommendations to deal with it.

This two-site First National Conference on Elder Abuse is significant and important in drawing national attention to a tragic problem. On behalf of the sponsor of this conference, Legal Research and Services for the Elderly, I want to commend this subcommittee for its concern with and commitment to dealing with problems of elder abuse and for holding congressional hearings here in San Francisco today and in Cambridge last week, with Congressmen Biaggi and Frank presiding, in conjunction with this conference.

It has been a pleasure for the staff of legal research to work with your staff, in particular with Kathy Gardner, in setting up this cooperative venture.

A decade ago when the first protests were heard about abuse in nursing homes, some said that these were isolated cases and that the problem was greatly exaggerated. This committee took the leadership to pursue and investigate the problem and can take credit for bringing the awareness and knowledge of the magnitude of abuse in nursing homes into public consciousness and taking steps to correct some of the more flagrant abuses.

There are those who now say that reports of elder abuse or neglect of elder persons by their caretakers in the community are also isolated and greatly exaggerated events. The experience of the practitioners attending the conference both here and in Cambridge would seem to provide convincing and overwhelming evidence that this is not so and that, to the contrary, elder abuse, neglect, and exploitation is a national tragedy that requires national attention.

Once again, this committee is providing that national attention to focus on the problem. For that, you have our appreciation.

Along with Ed Villmoare who represents National Paralegal Institute, a cosponsor of this conference, I would like to share with you a few major themes of this conference. I will be brief, because the full report of the conference, including recommendations, will be forwarded to you in writing for entry into the record of this hearing.

The first has to do with the paucity of research about elder abuse. There have really been only four exploratory studies conducted, and I would still submit to you that the data are very scanty. Anytime one approaches an agency or the Federal Government to request funding to deal with the problem, what happens is a numbers game—"give us a percentage, give us some figures." Quite frankly, none of us can responsibly provide such data. Any numbers or percentages that we use are strictly guestimates.

I note that H.R. 769, the Oakar-Pepper Bill, would create a national center on elder abuse which would conduct extensive research about the dimensions of elder abuse. We strongly support that provision.

A second theme of this conference concerned the need for a coordinated system of protective services. There was considerable amount of debate on whether that should be an age segregated protective services system, or whether it should build on what we already have in our States and localities to deal with other kinds of domestic violence.

At the present, there is no "system" and a model protective services system needs to cut across many professions, medical, legal, mental health, and social service.

Currently, there is a great deal of disorganization and confusion among these fields as to whom is the lead agency in this sort of an effort, and whose responsibility is what. We hear case after case of an elderly person who got bounced around like a hot potato to six or seven agencies before anyone dealt with the problem, if indeed, he or she was lucky enough to have that happen. Role clarification of each component in a coordinated response system is essential to prevent this sorry state of affairs.

I had intended to read off some of the general characteristics and specific services that need to be included in a protective service system, but, frankly, I think from comments you have already received, particularly from Mr. Chiplin and Mr. Gilfix, I would just be repeating things that you already know, and will include in your proceedings. In any case, they are available from LRSE studies.

I would like to share with you one final concern that was expressed both here and in Cambridge, and also has been alluded to by other speakers. That is the serious reservations we all have about setting up any protective service system that would expose the victim to worse consequences than he or she already faces in their immediate situation. Much of the resistance of the victims to acknowledge and deal with the situation can be attributed to fear that the alternatives to their situation are even worse than the abuse they endure in their homes.

Placement in nursing homes is often dreaded by the elderly and to many it is a cure that is worse than the illness. The Oaker-Pepper bill calls for the use of a least restrictive alternative and we support that, but I think that we must make sure that the resources are available to make that philosophy and commitment feasible before we expose the elderly to even greater danger by mandatory reporting of suspected abuse without an array of supportive services to resolve the problem without always resorting to removal of the victim to an institution.

We all must proceed responsibly and thoughtfully in developing our responses to abuse so that we do not end up, figuratively speaking, finding that the operation was a success, but the patient died.

In an era of anticipated cutbacks in the financial support of health and social services, particularly through titles XIX and XX and Older Americans Act, title III, that are essential to alleviate abuse, we must be careful that we do not identify abuse and abusers without being able to provide the kinds of services that would resolve the problem. Thank you.

Ms. OAKAR. Thank you very much. Since you did bring up the bill, I feel compelled to respond somewhat for the record. Without respect to the point, Margaret, that you made about isolating the elder abuse problem as an issue or services, one of the things that the committee study does provide that is really a very interesting point to me is that only 6.6 percent of the services available do go for the elderly in this particular case. And we believe that there is 25 to 40 percent need.

And while we would like to see a comprehensive approach to services for all Americans, the fact is that it is not taking place now. That is why we felt that it might be this need at this moment.

We do not feel, I want to say also, that the domestic violence approach which centers, I think you will agree, on the battered woman, which I, of course, have been a major sponsor of in the past and hope to support in the future and child abuse problems, should be in competition for funds and so on. We would never want to see that happen and would certainly support a comprehensive view.

With respect to the view concerning immunity from the law and the idea of mandatory reporting, one of the problems, as you know, that so many providers are faced with, along with perhaps neighbors and so on, is that they are subject to criminal penalties should they not be able to prove every little detail of what they are reporting.

I can think of cases in my own city whereby elderly people, an elderly woman, for example, was brought in with a fractured skull, and the social worker and the doctor had served the individual in the emergency room and were almost positive that the family members were responsible. What were they to do in a situation like that, just let it go unreported, or face the reality that they may be penalized, as the courageous woman who testified on behalf of one of our abused elderly who took the person in her home because of the problem? Under law, she was not really protected. And so that is why we felt that that was important.

Another situation that I can think of is the case of a 96-year-old woman who was raped in a nursing home and one of the aides who needed that $3 an hour job knew that there was another aide victimizing patients or people living in the nursing home in that way, and she was very, very fearful of the consequences. And that is why we felt that the immunity provision was very, very important.

Another thing that I would call your attention to, with respect to the bill, is that we do not want one provision, but not the other, passed. One of the points about it is that it does provide for services to deal effectively with the special problem of elder abuse.

It also provides for training for personnel, administrative procedures and institutions and other facilities related to the problem, so we are keenly aware of the problem with respect to having some provision for reporting and then what do you do with the individual. And we do feel that that is a facet of the bill, along with other recommendations beyond this bill that are in the report that Kathy and others did such a fine job in helping prepare.

The last point that I would like to make is that the bill does provide that the abused, neglected, or exploited elderly person participate in decisions. And I think we saw today from the two or three witnesses that we heard from who were abused that they were able to know what their problem was, and I think that Mr. Alexander was suggesting the same type of idea.

We think that is an important point, that they ought to be part of the participation and at the same time not be held out there to be further abused, if this situation does surface. But what is the alternative, if no one knows about the abused? They will just keep being abused and without any potential for being helped. And that is our fear and that is the gist of the reaction with respect to our introducing this bill.

We do not feel that elderly people should be treated as children. And while there are parallels in both bills, what we are saying is, like children, they are, when they are abused, very vulnerable to not being able to help themselves. It is with our respect for their age and wisdom that we did introduce the bill. So I would hope that that rather simplistic notion, if I may say say so, is eradicated because that is not our intention, but we certainly welcome your recommendations. We know that the people who participated are in the best position to offer solutions.

We hope that for those who do support this bill or other ideas in terms of finding solutions that you will please let your voices be heard, because if we do not, if Congress, or those who are in a position to do something about the situation, whether it is service providers or legislators, et cetera, under the State or Federal or local level, don't hear from the people in this country, then some of the programs that you hold very dear to you that already exist and some of the future programs that could help alleviate this problem would be eradicated.

And it is very very important that we have a sincere lobbying effort in finding some solutions and offering solutions, particularly, from those of you who are in a position to really be primary sources concerning this.

I really want to thank you both very much. And I want to thank the people who participated in this area, and all of the people who were part of the conference.

The subcommittee stands adjourned.

[Whereupon, at 1 p.m., the hearing was adjourned.]

APPENDIX 1

Elder Abuse and Neglect: A Guide for Practitioners and Policy Makers

(Designed and edited by Edwin Villmoare and James Bergman)

PREFACE

This manual attempts to provide an overview of elder abuse that is useful to both practitioners and policy makers. It reviews the current research; presents intervention strategies and protocols; discusses model delivery systems and legislation; and provides information and materials for practitioner training and public education.

Knowledge of the nature and causes of elder abuse is limited. Still less is known about treatment and prevention. This manual should be read not as a definitive statement but rather as a guide to the exploratory steps that have been taken in the field.

This manual is general in nature, except for the review of Oregon laws and resources in Part V. Any person or agency working with elder abuse in a state other than Oregon should have a comparable review prepared for that state.

PART I: ELDER ABUSE AND FAMILY VIOLENCE IN THE HOME: A REVIEW OF THE RESEARCH

Old age is no guardian against the forces that breed violence in the home. Child abuse and spouse beating are now common knowledge, if their causes and cures are less well understood. Since the late 1970's a third form of family violence, no less shocking or socially damaging, has emerged into public consciousness: elder abuse. In its most flagrant and disturbing form, it consists of a dependent elderly parent "cared for" and battered in the home by a relative, often an adult child. Elder abuse is not a new phenomenon any more than child abuse or spouse beating. All three can be traced throughout history. What is new in America is the growing determination to examine these problems, even at the expense of lost illusions about our own innocence. Child abuse and spouse abuse have been documented, political action galvanized, and legislative reforms initiated. These are beginnings.

Now is the time to take similar steps to investigate and address elder abuse in its various forms. The victims and potential victims of elder abuse are an extremely vulnerable group, physically, psychologically and financially. They are comparatively powerless in our political system. Without improved understanding of their situation and a commitment by society to a wide range of assistance and reform, their vulnerability and suffering will continue.

Chapter 1—The Current Research On Elder Abuse

Most of the information on elder abuse and neglect is contained in four research studies, all completed in the last two years. The following is a review and analysis of their findings.

1. *Elder Abuse in Massachusetts: A Summary of Professionals and Paraprofessionals by Legal Research and Services for the Elderly.*

The purpose of this survey conducted in March and April, 1979, was to gain descriptive information on the extent of the abuse of elders residing at home by their families, friends and other caretakers. Specifically, information was sought to answer the following questions:

Which professionals encounter abuse?
What are the characteristics of the abused and the abusers?
What kinds of incidents occur?
What responses are made by the helping professions?

For the purposes of the survey, abuse was defined as "the willful infliction of physical pain, injury, or debilitating mental anguish, unreasonable confinement or deprivation by a caretaker of services which are necessary to maintain mental and physical health."

Results are based on 332 responses to a survey of 1044 professionals and paraprofessionals. This is a response rate of 32%. Fifty-five percent (55%) of those responding cited an incident of elder abuse within the prior eighteen months. The majority of citings were reported by visiting nurses, hospital social service directors, and private social services agencies.

Physical trauma constituted over 41% of the reported injuries and included bruises, welts, cuts, punctures, bone fractures, dislocations, and burning. Other types of abuse less frequently reported included verbal harrassment, malnutrition, financial mismanagement, unreasonable confinement, over-sedation and sexual abuse.

The profile of the victim that emerged was that of a very old person (36% were over 80; 54% were over 75) with a significant physical or mental impairment (75%), female (80%) and living with the abuser (75%) who was usually a family member (84%) and who abused the victim on a recurring basis (78%).

The abuser was most often a relative (86%) living with the victim (75%). Sons, husbands, and daughters were the largest categories of abusing relatives, accounting for 24%, 20%, and 15% of all abusers reported. The abuser was reported to be suffering some form of stress (74%), with alcohol and drug abuse cited most frequently (28%). The elder was judged to be a source of stress to the abuser (63%) due to the high level of physical and emotional care required of the abuser (48%).

Questions designed to yield information about income level and incidence of other types of abuse in the family yielded unusable data.

Among the number of responses made by agencies encountering abuse, placement or attempts at placement of the victim ranked high. Where direct action was taken by an agency, placement was the single step most often taken or recommended (36%). When emergency action was taken, removal or recommended removal of the victim from the home was the course of action in over half the cases (56%).[1] When referrals were made, they were most often to social service agencies (48%), including mental health clinics, home care corporations, hospital social services, family services, visiting nurses, and public welfare agencies. Legal services represented 20% of all referrals.

Barriers to service provision were cited in 70% of the responses, particularly the refusal of the victim to acknowledge the problem or allow corrective action to be taken. In 45% of the citings, respondents indicated that the problem was resolved, although the responses tell little about the actual status of the abuse situation.

Main limitations of the survey:

The sample was not random, and therefore the results cannot be generalized.

The 183 citings do not necessarily represent 183 separate cases since respondents could have been reporting on the same case.

Certain "opinion" information was requested.

Responses based on memory as opposed to written cases were acceptable.

2. *Maryland: The Battered Elder Syndrome: An Exploratory Study by Marilyn Block and Jan D. Sinnott*

The purposes of this study, conducted at the University of Maryland, were to make preliminary estimates of the prevalence of physical and psychological abuse of elders by their adult relatives, to develop a model describing different types of maltreatment and to test different research methods for feasibility, cost, adequacy and usefulness.

Four types of maltreatment are defined, which taken together, describe what the authors call the "battered elder syndrome". The four are:

Physical abuse: malnutrition; injuries such as bruises, welts, sprains, dislocations, abrasions or lacerations.

---

[1] "Removal" refers to emergency intervention to take the elder out of the home/abuse situation temporarily. "Placement" refers to finding a long-term alternative living situation for the client.

Psychological abuse: verbal assault, threat, fear and isolation.

Material abuse: theft or misuse of money or property.

Medical abuse: withholding of medications or aids required (i.e., false teeth, glasses, hearing aid).

The reported findings are based on a final sample of 26 cases: 4 from agency records, 3 from responses by a random sample of community-dwelling elders to a mail survey, and 19 from responses by individual professionals to a mail survey.

The profile of the abused that emerges from the data suggests that the abused elder is older than average (mean age: 84; range 60–992), female (81%), Protestant (61%), lower or middle class (15% and 58% respectively), and living with relatives (76%). Nearly half manifest a moderate or severe mental impairment and only 4% are free from physcal impairments.

Nearly 80% of the abusers are relatives, primarily children of the victim (42%), who tend to be in their forties and fifties (53%). The majority are female (58%), white (88%), and middle class (65%). The abuse incidents were often repeated (58%) and were done more for psychological reasons (58%) than economic reasons (31%), according to respondents.

Results indicated that psychological abuse was more common than physical abuse. (The four separate behaviors identified under psychological abuse had frequent rates of 46%–58%). The most frequent types of physical abuse, lack of personal care and lack of supervision, both occurred in 38% of the cases. Beatings were cited in 15% of the cases.

Extrapolating from the data, Block estimates a national incidence of 4% of the elder population (or approximately one million victims), a figure comparable to the incidence of child abuse. Block concludes that elder abuse is similar to other forms of dependent abuse in that it is repetitive and committed by family members suffering from stress, especially economic stress. She contrasts it with other forms, however, by stating that the abused elders usually sought some form of help but were unable to find it. This would seem to suggest that learned helplessness is not a primary cause of elder abuse.

Response rates to survey questionnaires were low—negligible from agency records, slightly over 16% from community-dwelling elders and about 31% from individual professionals. Although the advantage of each method is explained, none is specifically recommended.

Major limitations of this study:

The sample was very small and non-random, and therefore the results cannot be generalized.

It is not clear that duplicate reporting of cases was eliminated.

The survey asked for some information based on opinion, not fact. It is often difficult to judge the victim's financial status, reason for attack, and the extent to which action was taken. This also raises questions with respect to the middle class nature of abuse, the suffering of economic and psychological stress by the abuser, and the apparent refutation of learned helplessness as a factor in abuse.

3. Michigan: A Study of Maltreatment of the Elderly and Other Vulnerable Adults by Richard Douglass, Tom Hickey, and Catherine Noel

The purposes of this study, conducted at the Institute of Gerontology and the School of Public Health at the University of Michigan, were to ascertain the extent of abuse and neglect of elders and other vulnerable adults, identify its characteristics, identify potential case finding procedures, and relate the findings of social etiology of these problems to the psychosocial literature on domestic violence. The year-long project was completed in November, 1979.

Personal interviews with 228 professionals in five community sites constituted the primary method of investigation for the domestic portion of the survey. An additional 36 interviews with staff of 12 nursing homes were conducted to form an institutional survey. Secondary data analyses were performed on nursing home intake forms for publicly supported clients in Michigan and on Detroit Police Department records of crimes against the elderly in 1978. The purpose of the former was to ascertain the extent of impairment and the potential for alternative care at home by families. The purpose of the latter was to determine the extent of criminal charges involving violence by family members toward elders.

A typology of maltreatment was developed with four categories:

Passive Neglect: includes being ignored, left alone, isolated or forgotten.

Active Neglect: includes having needed things withheld, such as companionship, medicine, food, exercise, or assistance to the bathroom.

Verbal or Emotional Abuse: includes name calling, and being insulted, treated as a child, frightened, humiliated, intimated, or threatened.

Physical Abuse: includes being hit, slapped, bruised, sexually molested, cut, burned, or physically restrained.

Based on their interviews, the authors conclude that abuse and neglect of elders and other dependent adults by their caretakers does exist although it is not pervasive. Most prevalent, according to the sample, was passive neglect, followed by verbal and emotional abuse. Active neglect and physical abuse exist to a far lesser extent in the experience of community practitioners, although respondents in virtually every profession had some experience with explicit evidence of physical abuse.

Direct experience with particular types of abuse and neglect varies widely by profession. For example, familiarity with financial abuse was cited particularly by lawyers and judges while physical abuse was more likely to be encountered by caseworkers and mental health workers. Geographically, it appeared that reports of maltreatment were higher in urban/metropolitan areas, although it may be that the higher level of services available and the greater anonymity in an urban setting may lead to more adequate case recognition.

To elicit information about casuality, practitioners were asked to select the most and least important casual factor from a list of four hypotheses previously developed by the authors based on their review of the domestic violence literature. Briefly, the four hypotheses are:

Dependencies incurred in old age increase the risk of abuse or neglect.

A child who is abused or who witnesses abuse grows up to be an abusive adult (i.e., transgenerational family pattern).

Life crises, in either the abused or abuser, trigger abusive behavior.

Environmental factors play a major part in bringing about neglectful or abusive behavior.

No pattern emerged that indicated one cause more important than another. Respondents did, however, raise other reasons for maltreatment, most commonly economic factors, alcohol abuse by either perpetrator or victim, and the general inability of some caretaker families to meet the needs of a dependent adult. Behavior of the victim, such as aggression, belligerence, or disorientation, were also cited as possibly provoking neglect and hostility toward dependent adults.

The authors noted as most significant the fact that so many respondents reported little or no regular, direct experience with any of the categories except passive neglect. Self-referral or referral by friends was consistently mentioned among all provider categories. Lawyers, caseworkers, adult service workers, and nurses also indicated high rates of referral from agencies.

Few professions had established reporting or intervention procedures specifically designed for domestic maltreatment of vulnerable adults. While several systems were equipped to intervene in obviously criminal behavior or on behalf of persons with no home or no personal resources, such protective services were far less common for adults in the care of relatives and friends.

In the institutional study, nursing home administrators, nurses and aides did not consider abuse or neglect to be a major problem in their homes. This conflicts with results of investigations of some of those homes by private and public agencies in Michigan.

The analysis of nursing home intake forms for 300 Medicaid patients indicated for the majority a multitude of severe physical problems requiring extensive medical and personal care. If dependency is associated with a higher probability of maltreatment, then this group is at an elevated risk. However, if this group were to become dependent on their families, a very great demand would be placed on the family members. Given existing resources and procedures, nursing home placement appears to offer the most appropriate care to meet the needs of the majority of such persons, according to the authors.

The analysis of reported crimes against the elderly in Detroit in 1978 indicated that a relatively small proportion involved family members and acquaintances. Relatives were implicated in only 1.5 percent of assault crimes and 0.2 percent of non-assault crimes; acquaintances account for 5.3 percent and 1.7 percent respectively.

The limitations of this study:

The sample is not a probability sample and cannot be generalized to larger populations.

The kinds of data collected and the methods of tabular presentation make quantification extremely difficult.

The survey called for subjective judgments of practitioners without referral to specific case records.

Data included opinions of those with no direct experience with maltreatment.

4. *Ohio: "Abuse of the Elderly by Informal Care Providers" in Aging, September/October 1979, by Elizabeth E. Lau and Jordan I. Kosberg*

The purpose of this study, conducted at the Chronic Illness Center in Cleveland, was to describe the types and extent of abuse of elders living in the community and dependent upon family or others for services necessary to enable the elders to remain in the community.

Lau and Kosberg classified abuse into four types:

Physical Abuse: includes direct beatings; withholding personal care, food and medical care; lack of supervision.

Psychological Abuse: includes verbal assaults and threats; provoking fear; isolation.

Material Abuse: includes monetary or material theft or misuse.

Violation of Rights: includes being either forced out of one's dwelling or forced into another setting (most often a nursing home).

A fifth category, self-abuse, is discussed in the report, but not used in the tabulations.

The methodology used in this descriptive research was a retrospective review of all case records of clients over 60 being served through the Chronic Illness Center. Workers received 404 cases, initiated in a twelve month period ending May 1978.

Based on the study's definition of abuse, a total of 9.6 percent (39 individuals) of all elders seen by the agency were determined to have experienced some form of abuse during the year.

The profile of the abused elder which emerged from the 39 cases is that of a severely impaired person (over 75 percent had at least one major physical or mental impairment), female (77 percent), widowed (58 percent), white (75 percent), and living with relatives (66 percent).

Physical abuse occurred most frequently, existing in nearly 75 percent of all cases. Within this category, the most common incident was lack of personal care (49 percent) although direct beatings occurred in 28 percent of the cases.

Psychological abuse characterized 51 percent of the cases, with verbal assault occurring frequently (33 percent of all cases). Material abuse (31 percent) and violation of rights (18 percent) were less common phenomena.

In a single case, there was likely to be more than one form of abuse occurring. Researchers found a range of one to eight forms per client with most experiencing two to five forms of abuse.

The most common reactions of the abused person were denial or resignation. In only four instances did the abused person seek protection. This supports intake data which indicated that the presenting problems for referral to the Center were health problems. Abuse was uncovered only after staff investigation.

Of a total of 46 different abusers, over 90 percent (all but four) were relatives. Abusers were daughters twice as often as any other relative (31 percent), followed by sons, granddaughters, husbands and siblings (usually sisters).

In analyzing outcomes, researchers found institutionalization, occurring in 46 percent of the cases, to be most common. Assistance was provided in 28 percent of the cases, including nutrition, homemaker, recreation and guardianship services. In 26 percent of the cases the problem continued due to denial both by abused and abuser and the refusal to accept intervention.

The major limitation of this study is its narrow focus. It concentrated on a group of elders already identified as chronically impaired and already involved as clients of one agency in a single metropolitan area. For these reasons, its findings cannot be generalized to a larger population, nor can estimates of incidence of elder abuse be extrapolated from its findings.

DISCUSSION OF THE FOUR STUDIES

What conclusions, if any, can be drawn about the nature of elder abuse from the four studies? To what extent are the studies consistent with each other? How do they add to our knowledge about the phenomena of elder abuse and what future directions do they indicate for research?

Severe physical or mental impairment as a characteristic of the abused elder is consistently and strongly supported by the three studies which developed profiles of the abused (Massachusetts, Maryland and Ohio). The Massachusetts study found that significant disability cut across all subcategories of age and appeared to be present in a much higher percentage of the abused survey population than in the elder population as a whole. Further investigation is warranted, however, to determine conclusively whether disability is independently correlated with abuse or simply a function of the sampling done (i.e., agency caseloads have a higher percentage of disabled clients).

The profile of the abused as being very old is supported by the Massachusetts and Maryland research which are the only two that investigated age. Females as the predominant class of victim was also affirmed (Massachusetts, Maryland and Ohio). Even when analyzed according to the male-female ratio in the national elder population, the Massachusetts study found a disproportionately high percentage of women as victims in each subcategory of age.

All three studies which profiled abused persons supported the contention that the abused tends to be victimized by relatives, lives with those relatives, and experiences repeated incidents of abuse.

Characterization of the abuser as a relative, living with the victim, is also confirmed as the converse of these characteristics of the abused.

No reliable estimates of incidence are available from the research because of the non-representative nature of the sample groups. Within the studies, incidence ranged from 4% to 55% of the sample population. The 4% (Maryland) estimate is most reasonable given the survey sample of community elders, but the sample size makes it suspect.

Major problems occur in attempting to compare findings on types and frequency of abuse. These problems are due to the lack of consistency in defining types of abuse. For example, what one researcher (Maryland) includes as physical abuse (lack of personal care and supervision) another (Michigan) will label as active neglect; and yet another (Massachusetts) will exclude altogether. Even when the definitions are somewhat comparable, as in the Maryland and Ohio definitions of physical abuse, the presentation of the data and the basic differences in the types of samples makes it inadvisable to draw conclusions with any degree of confidence. Conflicting results as to whether psychological or physical abuse is more prevalent may relate to these differing definitions and to sampling differences.

Perhaps the only general statement that can safely be made is that three of the four studies found a significant level of both physical and psychological abuse among the populations they surveyed. The exception is Michigan, where the definition was extremely narrow and where responses were not case-specific and not quantified.

The response to abuse by agencies indicates a trend toward removal or attempted removal of the abused from the home and placement in an institution (Massachusetts, Ohio). Data on resolution of the problem are unclear because they tell very little above the actual status of the abuse situation and the appropriateness or the effectiveness of the intervention. Information contained in all four studies does not indicate the existence of barriers to intervention and resolution of abuse cases. These barriers consist mainly of ethical dilemmas concerning the client's right to refuse service, lack of legal authority and protection for workers, and lack of clear agency policy and procedures for handling cases of elder abuse.

The research findings clearly give strong support to the impairment/dependency theory of the etiology of elder abuse. Theories involving individual pathology, demographic and social changes, and attitudes toward elders and disabilities were not specifically addressed in any of the research designs, nor was original data presented which would confirm or refute these theories. (For a review of elder abuse causation theories, see Chapter 2.)

Research did include questions geared toward testing whether theories about family dynamics were factors in elder abuse. Specifically, the Massachusetts study attempted to elicit data about other types of abuse occurring in the family. Because the majority of respondents did not know whether other forms of violence existed, researchers felt the data did not lend itself to interpretation. The issue of whether patterns of family violence are transgenerational must await further research.

Attempts were made to investigate a number of external sources of stress to determine their correlation with elder abuse. The Massachusetts survey found in almost 75% of the cases the abuser was experiencing some form of stress—substance abuse (usually alcohol), a long-term medical problem, or financial difficulties. Alcohol abuse by either the perpetrator or the victim was also cited in the Michigan study as a reason for maltreatment.

Questions designed to ascertain income level of abusing families yielded data that must be viewed with caution. The Massachusetts survey yielded a high level of low-income families. However, there was also a very high no-response rate by professionals. It is likely that professionals do not know the total family income in many cases. It is also possible that respondents serve mainly low-income families. If that is the case, results should not be construed to mean that poor elders are more likely to be abused.

In contrast, the Maryland study states that abusing families are predominantly middle class. Since respondents were asked to judge only the economic status of the abuser, rather than supply income figures, this statement cannot be accepted with any degree of confidence.

One final comment should be made about efforts to relate factors drawn from the research on family violence to elder abuse. A recent unpublished study examined five factors drawn from the literature on family violence based on the assumption that factors involved in child and spouse abuse are similar to those in elder abuse (Westcott). Specifically, the study examined whether families who abused their elder relatives differed from those who institutionalized them (on the assumption that institutionalization is an alternative behavior pattern to abuse). The five factors were:

Previous history of abuse in the family.
A family member experiencing a problem with alcohol.
The physical capabilities of the elder.
Social isolation of the family.
Financial resources of the family.

The study found no significant difference between families who institutionalized and those who abused. Both groups had very similar profiles on all five factors. Although these findings may indicate methodological or conceptual problems with the research rather than the factual situation, it serves to caution us about the importance of control groups. We must be certain that variables identified as prominent factors in elder abuse do not in fact exist in similar proportions in the rest of the population.

The research done in the past two years has contributed to our knowledge about elder abuse in substantive ways. More importantly, it has served to raise public and professional awareness of the existence of problems of abuse and neglect. The information generated is provocative and challenges us to assess critically the strengths and weaknesses of research to date. Our goal should be to move beyond exploratory and descriptive studies by refining our research so that we can better understand the true extent, types, and etiology of elder abuse. This is essential if we are to develop strategies for intervention, treatment, and prevention.

Two major problems exist with the currently available research: lack of a common definitional framework and methodology.

As long as the definitions of the phenomena of abuse are inconsistent from study to study, comparability and collaboration will be limited. It would be most advantageous to the advancement of the state of the art if collaboration could result in the use of a common classification system. Only in this way can we be sure that several pieces of research which claim to be measuring abuse are indeed measuring the same thing. Given the fact that so little is being done to measure elder abuse, the field of adult protective services would benefit greatly from such professional collaboration.

With respect to methodology, a basic problem is the use of small and/or nonrepresentative samples. Each of the studies reviewed cautions against generalizing beyond the particular and unique data set. This casts doubt on the validity of their own specific findings. Lack of control groups also hinders our ability to understand domestic violence against elders. By not using a control group, we cannot know to what extent the characteristics attributed to individuals in the abusive situation apply to the population in general. The findings by Wescott illustrate this point.

In discussing approaches to research on child abuse, Gelles makes a point that is equally valid to elder abuse. To paraphrase, "elder abuse" at present is a political term, not a specific behavior which can be measured and tested. Research on elder abuse in the future must examine clearly defined, discrete behaviors which are measurable.

Systematic, broad-based data collection related to elder abuse is also needed. There is currently a wealth of empirical data potentially available in states which have mandatory abuse reporting laws. Development and adoption of a carefully designed uniform data collection system would allow aggregation and comparison of this largely untapped source of information.

CHAPTER 2—THEORIES OF CAUSATION

There is very little theory in the field of elder abuse and neglect which is unique to elder abuse. Theories in this field draw heavily on family violence research. Each of the studies discussed earlier refers to the major theories which have emerged in the study of child and spouse abuse. A common and logical approach has been to test selectively those theories which seem to be most plausible as explanations of elder abuse.

The following summarizes the major theories on the causes of elderly abuse.

IMPAIRMENT

Elders most likely to be abused are those with severe physical and/or mental impairments. Impairments are thought to lead to dependency which results in a high level of vulnerability to abuse. Indeed, some researchers use the generic term dependent abuse to describe conditions of domestic violence. Furthermore, dependency has long been a condition associated with child and spouse abuse. Lau and Kosberg take the view that impairments increase vulnerability to abuse as the basic assumption underlying their research. One of the four hypotheses in the Michigan research is that the normal dependencies incurred by old people increase their vulnerability to abuse or neglect by people in their domestic situation. Based on a prior literature search on family violence, researchers at Legal Research and Services for the Elderly designed their survey of elder abuse with the theory in mind that the abused elder was likely to be very old and/or dependent on the abuser for care. The presence of a severe impairment was also a basic hypothesis of the Maryland study.

A corollary to the impairment theory is the concept of learned helplessness. As dependency increases due to impairment, a person may come to feel that s/he is powerless to control life, that no efforts s/he can make will affect the outcome of a situation. This perceived lack of control, whether realistic or not, may accelerate dependency and contribute to abuse. Learned helplessness is similar to the learned role model theory formulated for spouse abuse.

INDIVIDUAL PATHOLOGIES OF THE ABUSER

The basic premise of this theory is that the abuser has personality traits or character disorders which cause him/her to be abusive. Research on elder abuse has benefited from the advances in theory on other types of abuse to the extent that it is now generally recognized that individual pathology, as a sole cause of abuse, too simplistic an explanation. Nevertheless, individual predisposition to committing abuse remains one factor to be considered.

The Michigan study observes that one underlying cause of abuse is the flawed development of the abuser, although it is more useful to view it as a learning disorder rather than a disease. One of the hypotheses in this study was that maltreatment behavior, whether of a child, a spouse, or an older person, may well originate with developmental deficiencies arising earlier in life. This, combined with family structural factors, may produce abusive behavior in some people.

A second concept related to individual causality is that of the "non-normal" caregiver, a term used in the Ohio study. This would include, for example, situations in which parents have cared for a mentally ill, retarded, or alcoholic child. As the aged parents weaken and require care themselves, the adult child becomes an abusing and/or neglecting caretaker because of an inability to make appropriate judgments. This concept is also useful to describe cases where the caretaker is elderly and has experienced such organic brain deterioration that s/he is not aware either of his/her own behavior or of the effects of that behavior.

INTERNAL FAMILY DYNAMICS

A major premise in the theory of causality of domestic violence holds that violence is a normative behavior pattern learned within the context of the family. According to this theory, the child learns from observation and participation within the family that violence is an acceptable response to stress, and even learns a variety of scripts for future violent behavior. This establishes a cyclical pattern in which each generation learns violent adaptive behavior from the preceeding generation, practices it, and, in turn, passes it on to succeeding generations.

Behind Closed Doors: Violence in the American Family by Gelles, Steinmetz and Strauss (1980) appears to confirm that "violence begets violence" in the American family. This study of a representative random sample of over 2000 families indicated high correlations between the personal observation of family violence or victimization in childhood and later experience with family violence in adulthood. Unfortunately, this study did not examine abuse of the elderly. Researchers in family studies, however, have raised the logical questions of why we should assume that family violence stops at middle age. (Chapter 3 examines Behind Closed Doors in greater detail).

Failure to resolve the filial crisis is another "family dynamic" concept applicable to elder abuse. According to this theory, the healthy development requires the adult child to go beyond a state of adolescent rebellion to one of emancipation from parents. Eventually, the mature child sees the parent as an adult with an identity beyond the parental role and establishes a relationship on this basis. Failure to move beyond adolescent rebellion can mean permanent "war" on the parent and hence abuse.

The internal stress that can be placed on a family by the burden of care for an older relative is also cited as a potential cause of abuse. O'Malley describes a number of studies indicative of high levels of anxiety, headaches, insomnia, and depression among family caregivers. A New Zealand study found that on an average, chief caretakers spent 28 hours per week—the equivalent of a part-time job—providing physical and psychological assistance to frail older family members. Two-thirds of these caretakers reported negative effects on their health, including fatigue, anxiety, and general deterioration (Koopman-Boyden and Wells) Block describes that adult children, looking forward to a freer, more relaxed lifestyle after their childrearing years, may not welcome the caretaking role. Responsibility often falls on only one adult child in the family who may regard it as a burden without relief. Where children still reside in the home, a middle-aged caregiver, usually a woman, may be caught between the needs of her husband and children and the needs of her parents and/or in-laws.

When a parent moves in with adult children, it can disrupt the family routine. Power conflicts can develop between the elder and other members of the family over freedom of activity, household procedures, and discipline. All these factors can lead to unrelenting stress on someone ill-equipped to cope with it.

EXTERNAL STRESS

Research on family violence in the 1970's increasingly recognized the importance of external stress on the family as a major factor contributing to violence. How much stress and what types of stress are most likely to be found in abusive families is a major theme of Behind Closed Doors. The authors found that certain social factors appear to be important correlates to domestic violence—in particular, age, income, and employment status. Of lesser importance were religion, urban/rural residence, region, and race.

DEMOGRAPHIC AND SOCIAL CHANGES

The literature on aging repeatedly cites demographic trends which may exacerbate the potential for elder abuse. The elder population is increasing in size relative to younger age groups: the population 60 years of age or over has grown from 6.4% in 1900 to almost 15% in 1975; and the segment of the aged which is growing most rapidly is the "old old," i.e., persons over 75.

This means that today's middle-aged adult is more likely to have a living parent than counterparts in previous generations. Additionally, since family size has decreased steadily over the past hundred years, there are now fewer adult children to share the responsibilities of caring for a frail parent.

Care of the frail parent has customarily been the responsibility of married daughters or daughters-in-law who are at home caring for their children. The fact that 50% of all married women are not in the labor force by choice or by economic necessity means the pool of able and willing caretakers has shrunk at a time when the number of old people—especially the very old—has increased. These trends may well place excessive physical, emotionally, and financial demands on families. These in turn may be factors associated with elder abuse.

ATTITUDES TOWARD THE ELDERLY AND DISABLED

Block, in The Battered Elder Syndrome, theorizes that patterns of abuse and neglect may be reinforced by *ageism*. Ageism involves stereotypes that are negative in their appraisal of older people and their roles in society. Block cites a Harris Poll in which the image of older persons in America is that of "senile, lonely, used-up bodies rotting away and waiting to die." She notes that our expectations can distort our perceptions and that the resulting misperceptions may play a major role in creating situations conducive to abuse.

Since abused elders are thought to be characterized by severe disabilities, it is also useful to consider society's attitude toward the disabled. Nearly half of the non-disabled population has primarily negative attitudes toward the disabled, according to studies by English. Further studies indicate that the media, especially television and comic books, tend to portray evil characters as having physical disabilities or abnormalities, and that overall attitudes toward the physically and mentally ill are similar to attitudes toward the elderly. Black insists that the effect of negative attitudes toward aging be closely examined for the potential for creating abuse of older family members. For example, an adult child might justify unreasonable confinement of an aged parent on the grounds that "mother's too old and senile to know the difference."

CHAPTER 3—ELDER ABUSE AS AN ELEMENT OF FAMILY VIOLENCE: A SUMMARY OF BEHIND CLOSED DOORS

Behind Closed Doors is the first comprehensive national study of American family violence. This book is important to the understanding of elder abuse for three reasons:

It is the first comprehensive study of family violence using a large random sample broadly representative of American families as opposed to prior studies which were done on groups already identified as abusers. This strengthens the case for applying the findings to American families as a whole.

It tested measurement devices to score incidence and types of violent behavior and, more importantly, to predict family violence.

It encompasses and interrelates several discrete types of domestic violence, i.e., spousal, child, sibling and parent abuse.

Behind Closed Doors does not investigate elder abuse specifically, but its conclusions can generate hypotheses concerning elder abuse.

This chapter outlines the key themes of Behind Closed Doors. For more specific information, the original work should be consulted.

Before describing the findings, theories and recommendations of the study, its limitations should be reviewed.

The sample included intact families only, i.e., no single-parent families were included. This procedure reflects the stated intention of studying spousal violence.

The sample excluded interactions of parents with children under three years of age.

The response rate of 65% is lower than hoped for, although the authors feel that in light of the sensitive nature of the questions, it represents a significant accomplishment. The final size of the sample was 2,143 completed interviews. The sample population closely resembles the characteristics of the approximately 46 million American families in the United States in 1976 (with the exceptions noted above).

The study is confined to the social causes of violence. In part, this reflects the authors' conviction that social rather than personal variables represent most causes of family violence.

The findings may understate the extent of violence in the American family, given the first two limitations mentioned above.

The authors' definition of family violence is "any act carried out with the intention or perceived intention of causing pain or injury to another person." This definition covers everything from a slap to murder. The authors term this full range of violence "normal violence" because of the apparent frequency of all forms of violence in the family. The authors also selected the term "normal violence" and its inclusive definition to raise questions about all types of hitting within the family, including spanking. Both the term and its definition are controversial since many people regard slaps and spankings as legitimate and necessary teaching and disciplinary tools that should be free from association with the concept of violence.

Within the broad range of "normal violence," the authors identify a subcategory they call "abusive violence." This they define as "an act which has the high potential for injuring the person being hit," e.g., punching, kicking, biting, hitting with a hard object, beating up, shooting, trying to shoot, stabbing, or trying to stab.

Family violence is measured by responses to the Conflict Tactics Scale which enumerates 18 discrete behavioral responses, ranging from rational discussion to physical force, used to resolve conflict among family members. The Conflict Tactics Scale is as follows:

a. Discussed the issue calmly.
b. Got information to back up (your/her) side of things.
c. Brought in or tried to bring in someone to help settle things.
d. Insulted or swore at the other one.
e. Sulked and/or refused to talk about it.
f. Stomped out of the room or house (or yard).
g. Cried.
h. Did or said something to spite the other one.
i. Threatened to hit or throw something at the other one.
j. Threw or smashed or hit or kicked something.
k. Threw something at the other one.
l. Pushed, grabbed, or shoved the other one.
m. Slapped the other one.
n. Kicked, bit or hit with a fist.
o. Hit or tried to hit with something.
p. Beat up the other one.
q. Threatened with a knife or a gun.
r. Used a knife or a gun. (p. 256)

Responses to the last eight items provide the basis for statistics on the extent of general family violence. This includes the entire range of physical behavior from pushing and shoving to the most severe, such as shooting or stabbing.

Additionally, statistics were analyzed for severe violence only, i.e., those actions enumerated under the definition "abusive violence" (the last five items on the Conflict Tactics Scale). It is these more severe forms that are described under the general labels of wife-beating, husband-beating, and child abuse.

FINDINGS

Spousal Violence

In a one-year period, 16 percent of husbands and wives commit at least one violent act against each other. During the entire length of the marriage, 28 percent engage in at least one act of violence. This represents the percentage of persons admitting to such assaults.

The incidence of wife-beating, i.e., actions confined to the more severe forms of violence, was 3.8 percent for the year immediately preceding the study (one out of every 26 wives). Extrapolated to the population of American families, this means 1.8 million wives each year are beaten by their husbands.

The incidence of husband-beating is even higher, at 4.6 percent (one out of every 22 husbands per year). It is not clear, however, how much husband-beating is part of mutual violence or involves self-defense. Other studies indicate that husbands engage in more violent actions and do more physical damage.

Almost one out of every eight couples admitted to engaging in spouse abuse at some point in the marriage. Spouse abuse is a pattern for about half of the couples involved in it over a one-year period; for these couples, abuse is not an isolated event occurring only once or twice.

Responses to questions on the prevailing norms or attitudes about marital violence tend to confirm that for many a marriage license is a hitting license. A full 25 percent of the wives and 33 percent of the husbands felt that slapping is necessary, good, or normal.

Violence Toward Children

Interviewers randomly selected one child per family for study. Of parents with children between the ages of 3 and 17, 73% reported using violence at some time during the child's life. Use of milder forms was most common: 41% pushed or shoved the child in the study year, and 46% sometime during the life of the child. Spanking or slapping of the child was reported by 58% of the respondents for the year and 71% at some time during the child's life.

Extrapolating the findings of more severe forms of violence, the authors estimate that between 3.1 and 4 million children between the ages of 3 and 17 living with both parents in 1975 had been kicked, bitten, or punched by a parent at some time in their lives. Between 1 and 1.9 million experienced these actions in 1975. Between 1.4 and 2.3 million children are beaten at some point while growing up, and between 275,000 and 750,000 were beaten in 1975. Between 900,000 and 1.8 million have had a parent use a knife or gun on them in some fashion.

As with spousal abuse, there is a pattern of violence, with spankings/slappings occurring 9.6 times per year; kicking/punching/biting, 8.9 times; and beatings about 6 times.

Mothers are more likely than fathers to use violence, including "abusive violence," on their children. Possible explanations include: mothers spend more time with their children; they are held more responsible for the children's development; and children interfere with their plans and self-concepts more than the fathers.

Sons are more frequently the victims of violence than daughters. Younger children (aged 3–4) appear more vulnerable, suffering violence during childhood 86% of the time. This figure drops steadily to about 33.5% for teenagers aged 15–17. It should be recalled that children under three were excluded from the sample although other studies indicate they are the most vulnerable to abuse of all age groups.

Again, prevailing cultural norms support parents in their use of violence against their children for discipline and socialization. When asked whether slapping and spanking of a twelve-year-old child was necessary, normal, or good, 70% said it was normal and 71% said it was good.

Sibling Violence

Sibling violence is virtually universal. In 82 percent of the families, some violent act had occurred within the year; 53 percent of it was severe, i.e., kicking, biting, punching, or hitting with an object. Indications are that parents often view fights between their children as practice for skills that are required to deal with friends and schoolmates. Girls are only slightly less violent than boys.

CAUSES OF ABUSE

The theories of causation of family violence described in Behind Closed Doors can be summarized as follows:

> The norms of American Society as a whole support and legitimize the use of violence in the family to solve disputes, to train, to punish, and to control.
>
> Violent behavior is learned within the family context and becomes transgenerational. A significant percentage of persons who grew up in homes characterized by spousal or child violence in turn practices these forms of violence in their adult lives and passes them on to their own children.
>
> Social factors such as income, age, employment status, and education are related to domestic violence.
>
> Stress is a major contributor to family violence.

The authors cite answers to attitudinal questions in their own study as well as results of other attitudinal polls to support the first and underlying cause. They also point to the media—to television shows in particular—as presenting violence or threats of violence in situations intended to be comical or heroic.

To substantiate the second theory, the authors present statistics from their own study which indicate, among other things, that men who have seen their parents attack each other are three times as likely to hit their own wives. Roughly the same statistic held for women. People whose parents were never violent had the lowest rate of husband- and wife-beating (2 percent). The one-third of the respondents with teenagers who reported hitting their teenagers during the year had an almost identical rate of being hit by their own parents when they were teenagers (37.3 percent). Those who experienced the most punishment as teens have a rate of spouse beating four times greater than those whose parents did not hit them.

In addition to their own research, the authors cite other studies which indicate that murderers, presidential assassins or would-be assassins, violent prison inmates, and violent juvenile delinquents seem to have experienced frequent and severe violence as children.

Specific social factors were examined by taking the findings on violent families and analyzing them according to the following variables: region, city/county, race, religion, age, education, income, occupation, and unemployment. The analysis indicates that some of these factors do have strong bearing on inclination toward family violence. Most strongly related are:

Age. Younger families, those where the respondent was under 30 years of age, were more active statistically in every form of domestic violence.

Income. The lowest income families had the highest rates of family violence. This relationship is the strongest for spousal violence.

Employment Status. Families where the father was unemployed or employed only part-time had high rates of violence.

To a lesser extent, religion, urban/rural residence, region of the country, and race were related to violence in the home.

Under factors of stress, the following characteristics were analyzed: number of children in the family, a "stress score" (based on responses to a list of eighteen common stressful situations such as the death of a family member or loss of a job), the authoritarian exercise of power, and degree of shared decision-making in the home.

For those scoring above average in the stress test, the higher the score, the greater the association with child abuse. The correlation with spouse abuse was even higher.

The safest homes were found to be those with fewer than two children where the husband and wife experience little stress and where a democratic system is used to make decisions.

The authors point out that the standard treatment for violent families usually consists of personal counseling for the violent family member(s). This form of treatment is based on the assumption that something is "wrong" with such a person. Although the authors indicate that personality factors cannot be ruled out as a cause of family violence, they conclude that personal counseling will be inadequate to end or prevent violence that has as its primary causes social factors. In short, psychological help cannot effectively treat or prevent family violence caused by poverty, poor health care, or social norms that legitimize physical force.

PREDICTION OF ABUSE

In order to see if all the separate characteristics associated with spouse abuse make up a constellation which can be used to predict spouse abuse, the authors developed a list of the twenty-five most common characteristics called the Spouse Abuse Prediction Checklist. One point was assigned to each characteristic. An individual family's score could range from 0 to 25, depending on how many of the characteristics it exhibited. The Spouse Abuse Prediction Checklist reads:

Important for both wife-beating and husband-beating:

- Husband employed part-time or unemployed
- Family income under $6,000
- Husband a manual worker
- Husband very worried about economic security
- Wife very dissatisfied with standard of living
- Two or more children
- Disagreement over children
- Grew up in family in which father hit mother
- Married less than ten years
- Age thirty or under

Non-white racial group
Above average score on Marital Conflict Index
Very high score on Stress Index
Wife dominant in family decisions
Husband very verbally aggressive to wife
Wife very verbally aggressive to husband
Gets drunk but is not alcoholic
Lived in neighborhood less than two years
No participation in organized religion

Characteristics that are important for wife-beating:

Husband dominant in family decisions
Wife is full-time housewife
Wife very worried about economic security

Characteristics that are important for husband-beating:

Wife was physically punished at age thirteen plus by father
Wife is a manual worker. (p. 203)

Results indicate that the checklist is a useful predictive tool. Couples with only three of the characteristics have violence rates under 2 percent. The rates then increase sharply. Of couples with twelve or more characteristics, about two-thirds are violent. This tally referred to the total range of normal violence. A higher checklist score produced comparable results with regard to abusive violence.

The authors also developed a Child Abuse Prevention Checklist. The checklist predicted child abusers only about one-third of the time. This means it was wrong about two thirds of the time. The authors caution against the use of the checklists, particularly the Child Abuse Checklist, for predictive purposes. Checklists raise serious ethical and legal issues about the possibility of intrusive family surveillance and false labeling.

REDUCING FAMILY VIOLENCE

The authors describe several short-term solutions to protect victims and/or reduce stress:

The child welfare services must have adequate numbers of well-trained staff with the capacity for immediate intervention and for providing services which reduce stress, educate families in parenting, and offer continuity of care.

More emergency shelters and day care programs should be established.

Police should be given better training in handling domestic disturbances.

Courts need to streamline mechanisms for handling domestic violence cases.

Both police and courts must eliminate sexist attitudes and hands-off policies in dealing with abuse cases.

More family planning and individual and marital counseling should be provided.

The long-range solutions presented in Behind Closed Doors require reconsideration and alteration of some of our society's fundamental attitudes, values, and behaviors. They are:

Step 1.—Eliminate the norms which legitimize and glorify violence in society and in the family. This includes corporal punishment in any form.

Step 2.—Reduce violence-provoking stress created by society. This includes unemployment, poverty, and poor health care.

Step 3.—Integrate families into a network of kin and community. Since social isolation is so frequently characteristic of child abuse, membership in groups is needed to reduce isolation and alienation.

Step 4.—Change the sexist character of society and the family. Sexual inequality in the home and in society is at the heart of the battle of the sexes. It is a prime contributor to violence among family members.

Step 5.—Break the cycle of violence in the family. Reduce and gradually eliminate the use of physical punishment and develop alternative technologies for child rearing and education for parenthood programs.

By the author's own admission, these long-range solutions are monumental. They challenge our basic notions about the privacy of the family and are seemingly unworkable. The authors contend however, that the alternative is the continuation and perhaps the escalation of a deadly tradition of domestic violence.

PART II: HANDLING CASES OF ELDER ABUSE: FACETS OF INTERVENTION

General Principles

Efforts to assist in cases of elder abuse and neglect should be governed by the following six principles:

1. The Client's right to self determination

Competent adults are entitled to decide where and how they live and whether or not they receive social services and other forms of assistance. This concept embodies a number of basic civil rights.

2. The use of the least restrictive alternative in treatment and placement

This principle has emerged as a legal doctrine from the mental health area. It embodies the concept that society should intervene to assist people only to the minimum extent necessary; that an individual should retain maximum independent decision-making.

3. Maintenance of the family unit wherever possible

The evidence available strongly suggests that most victims of abuse and neglect will receive better care if the abuse or neglect is dealt with as a family problem and if the family is given the necessary resources and assistance to overcome the problem.

4. The use of community-based services rather than institutionalization wherever possible

Institutions such as nursing homes are no substitute for family life. They deprive older people of freedom and familiar surroundings. In most instances the older person is much happier if kept in the home and supported with services from the outside.

5. The avoidance of blame

To place blame is generally dysfunctional. It may antagonize the abuser, making that person more difficult to deal with, and reduce the chances for terminating the abuse or neglect.

6. Inadequate or inappropriate intervention may be worse than none at all

Intervention and assistance that promise a great deal and deliver little, or come at the abuser and victim from all sides, may cause them to reject assistance now and in the future. In some instances, such unbalanced intervention may greatly increase the risk to the victim.

Chapter 4—Identification, Assessment, and Management

BARRIERS TO ACCESS

The Massachusetts report found that 70% of all the professionals responding to the survey indicated that some barrier to service provision existed. Of those respondents who reported barriers, the greatest percentage (36%) indicated that the refusal of the victim to acknowledge the problem constituted the barrier. This refusal was variously attributed to "fear of retaliation" from the abuser, feelings of kinship and love for the abuser, or simply as a refusal to accept services.

Fourteen percent of the surveys indicated that a legal problem constituted the barrier to care. Legal problems included:

Lack of legal protection for workers who intervene in the family situation.

Lack of eye witnesses to the abusive act (lack of proof) when the abused person refuses to file a complaint.

Lack of an appropriate person to accept guardianship for the elder.

Requirement of a formal complaint from the abused individual before police can act.

Unwillingness of witnesses to testify.

Lack of statutes protecting elders from manipulation/exploitation.

Thirteen percent of the surveys indicated that lack of cooperation of the abuser and/or family with whom the elder was residing was the principal barrier to services provision. An additional 11% stated that lack of services was the barrier. Needed services which were unavailable included protective services for adults, respite care facilities, temporary shelters able to care for persons requiring

74

assistance in activities of daily living, emergency foster care for elders, and nursing home placements. Lack of coordination among service providers was also cited in this category.

In 9% of the surveys, access to the elder was cited as the barrier to services provision, i.e., the worker was barred from entering the home by the abuser or family. An additional 3% of the surveys stated that agency attitudes were a barrier to service. Examples include: a worker deciding that the abuser was "not reachable by counseling;" an agency dropping the client because of an obstructive family; a doctor refusing to acknowledge the problem and take some form of action; and time demands of the case forcing a worker to reconsider his/her involvement with the case.

Perhaps the most difficult and dramatic barrier to access occurs when the worker finds that a relative discourages or even prohibits a meeting with the alleged victim. The worker may be forbidden to enter the house, the victim reported as too ill to see anyone, telephone calls intercepted by family members, or legal and physical threats directed at the worker.

Some workers, frustrated by such barriers, have resorted to using housing inspectors or landlords to investigate for them. Such approaches are usually illegal. Some workers call in the police to investigate. This approach has the unfortunate effect of criminalizing what is fundamentally a disturbed family relationship and of polarizing the relationship between the worker and the family. The presence of the police often precludes further serious efforts at improving conditions in the home. Institutional placement is then the only alternative remaining. In general, the police should be used only when the victim is believed to be in serious and imminent danger.

Better approaches to family and victim resistance to assistance include:

Offering services that can help both abuser and victim.

Checking eligibility for social, health, and income programs.

Avoiding reference to "neglect" or "abuse."

Sympathizing with family members who bear the burden of caring for the victim.

Focusing on the future by pointing out that conditions can be made better for the family.

Coming back when the resistant family member is out.

Approaching other family members.

Being patient.

Offering alternatives to abusive interaction.

Remaining friendly and concerned with both abusing/neglecting person and the victim.

Coming back a second and third time if necessary.

In the process of seeking access to a client/victim, the worker must evaluate his or her own personal safety, particularly in cases of violent abuse and where drugs or alcohol are involved. If the worker is apprehensive, he or she should consider taking a second worker or visiting the home with a neighbor. If all else fails, it may be necessary to call the police or, where the victim is incompetent, have a legal guardian appointed who can provide access or remove the victim from the home.[3]

SIGNS OF ABUSE AND NEGLECT

Absent confirmation by the client, the worker must make an initial determination based on all the available evidence. The following are signs that should be regarded as suspicious or at least grounds for further investigation of physical abuse or neglect:

bruises
welts
lacerations
punctures
fractures
evidence of excess drugging
burns
physical constraints (tying to beds, etc.)
malnutrition and/or dehydration
lack of personal care

---

[3] See Chapter 5 of this manual for information on legal issues and remedies for further discussion of intervention problems and theories.

inadequate heating
lack of food and water
unclean clothes and bedding
lack of needed medication
lack of eyeglasses, hearing aids, or false teeth

None of these conditions automatically indicates abuse or neglect. Older people, especially those with impairments or under medication, may fall down or otherwise accidentally injure themselves. Any caretaker may fail to provide needed services on any given day. In general, a cluster of these conditions or the recurrence of one or more raises the probability and should result in further investigation.

Other forms of abuse and neglect (those that are not physical) are much more prevalent and also more difficult to identify. Psychological abuse is a particularly difficult area. There is no general consensus on what fits into this category, and there may never be. Shouting, the display of strong emotions and the use of harsh language may be a social or cultural norm in a particular ethnic group. Words and emotions that may be harmful in one family are not necessarily so in another family. In this area the worker must take great care not to project his/her own attitudes and values. With this warning in mind, the worker should know that the following may signify the presence of psychological abuse:

threats
insults
harassment
withholding security and affection
harsh orders
refusal to allow travel, visits by friends, attendance at church

Before arriving at any conclusions based on the presence of these "psychological" actions, the worker should attempt to evaluate their impact on the older person. The following responses may indicate psychological abuse:

resignation
fear
depression
mental confusion
anger
ambivalence
isomnia

Any of these attitudes or mental conditions may result from a wide range of factors and may not be primarily caused by hostility or indifference by the caretaker or other member of the family. Remember, the victim, unless she/he is mentally disturbed, is ultimately the best source of information on whether or not there is abuse or neglect.

It should be noted that physical neglect or abuse is frequently accompanied by some form of psychological abuse and attendant psychological problems.

Financial abuse, or the misuse of the victim's income and expenses, is often extremely difficult to determine. Many people are by nature private about their financial affairs, and outside evidence is difficult to obtain. Again the victim is the best source of information about this subject, although in most cases of suspected financial abuse, the potential victim has turned management of his or her financial affairs over to another person. As a result, there may be some confusion about finances.

If financial abuse is suspected, the worker should seek information about income that covers:

interest on bank accounts
stock dividends
social security
supplemental security income
veterans benefits
pensions
disability benefits

With regard to resources, the worker should inquire about:

savings
real estate
stocks
jewelry
life insurance

The worker should attempt to determine if there is a power of attorney (written or oral) that gives someone authority to act in financial matters on the client's behalf. The worker should also ask whether or not a conservator has been appointed by a court to manage the finances of the client. The conservator will often be a member of the family in a position to misuse the client's property. However, if there is a court ordered conservator, reporting to the court (usually probate court) is required regarding expenditures. In many cases the whole situation will be extremely informal with a family member handling the financial affairs without making regular or clear reports to the client.

A second stage of inquiry concerning financial abuse should involve estimating whether the conditions surrounding the older person reflect the available finances. Check housing, level of personal care, nutrition, medical care, clothes, transportation, and social opportunities.

Are these adequate? Do they satisfy the older person? If there appears to be a discrepancy between the assets and the adequacy of these items or the satisfaction of the older person, there may well be financial abuse. Overdue client bills may also indicate financial abuse. In a number of reported cases, a family member or caretaker has misused client funds that should have been used to pay client rent and utility bills.

In addition to the specific signs and factors discussed above, the worker should be aware of the general profiles of both the abused and/or neglected victim and of the abusing or neglecting family member that have emerged from the available data. These two profiles may help to put isolated bits of evidence into context and increase the probability that the worker can determine whether or not abuse or neglect exists.

GENERAL CHARACTERISTICS OF ABUSED AND NEGLECTED PERSONS [3]

The four major studies undertaken in the field of elder abuse point out the tentativeness of their findings. In general, these studies are not adequate to provide a comprehensive set of characteristics of the abuser and his/her victim.

Yet, the completed studies provide an approach to the problem, and a victim profile does emerge. The Massachusetts study, The Battered Elder Syndrome, and the Lau and Kosberg studies all point out that the victim tends to be an "older" elderly person; with 55% of the citings in the Massachusetts survey found in persons above the age of 75. All three studies agree that abuse is observed to an overwhelming degree in elderly women (77% in Lau and Kosberg, 80% in Massachusetts and 81% in The Battered Elder Syndrome).

The victims of abuse usually live in the family environment with an adult child or other family member who abuses them.

The overwhelming majority of abuse victims suffer from one or more disabilities which place them in a vulnerable and service-demanding position. 75% of the Massachusetts survey respondents stated that the abused person had a mental or physical disability which prevented him or her from meeting basic daily needs. Block found that 62% suffered some form of mental impairment. Lau and Kosberg report that 41% suffered either partial or total mental confusion.

Although more research needs to be done, it is easy to imagine that a victim of abuse is usually a person in some discomfort who may need constant attention and in-depth care. In some cases the older person may act cantankerously, demand care, and use guilt as a motivating force.

The older person may need a special diet, special hygiene care and shows of affection and caring. In some cases there may be a history of family violence, alcoholism, drug abuse or other stress that may prevent the neglecter/abuser from caring for the elderly person. The vulnerable elder may have been an abusive parent.

In order to understand the psychodynamics at work in an abusive situation it may be helpful to put yourself in the role of a dependent and ailing older adult. The following exercise should assist you in understanding the victim's point of view.

Imagine yourself as an older person who is now incapable of caring for your own basic needs. You move into your child's home and away from the home you have known for many years.

Moving has brought up old memories of the family—memories with which you may not be entirely comfortable. Your relations with your children were never ideal and you may feel it's too late to establish good ties.

---

[3] For a complete analysis of the literature in the field of elder abuse, see Part I.

Now you are a burden on your children—people you never really knew as they were growing up. You may have even abused them at one time in a period of great stress.

Your promise of golden retirement is shattered by inflation, a small fixed income and, perhaps, the loss of a spouse. You may feel yourself deteriorating physically and mentally and there are times when pains assault you. Now you are forced to compete with your grandchildren for attention, affection and care.

You may feel trapped in this home in which your personal cleanliness, privacy, nutrition and medical needs are low on the list of family priorities. Passivity, boredom, resignation to filth and withdrawal become your means of escaping. At this point it seems hopeless to reach out for aid.

CHARACTERISTICS OF THE ABUSER

The Massachusetts Survey found that in 75% of the abuse citings, the abuser lived with the victim, with 86% of the abusers being relatives of the victim. The Battered Elder Syndrome found close correlation, with 81% of abusers being relatives of the victim. They also found that females (58%) more often than males are the abusers while the Massachusetts Survey found that sons (24%), husbands (20%), and daughters (15%) made up the largest categories of abusing relatives. Lau and Kosberg came up with results citing 30% of abusers as daughters, 14% as sons, 14% as grandaughters, 12% as husband/spouse and 12% as siblings (usually a sister) as victimizers.

According to the Massachusetts Survey, the abuser was usually experiencing some form of stress when the abuse occurred. 28% suffered from alcoholism or drug addiction while 18% complained of a long-term medical complaint, long-term financial stress (16%) and lack of needed services (9%). The Battered Elder Syndrome points to psychological (58%) and economic (31%) factors leading to abuse. 63% of the respondents to the Massachusetts survey indicated that the vulnerable elder requiring a high level of emotional and financial support was a source of stress. Abusers tend to repeat their abuse according to The Battered Elder Syndrome in 58% of the cases studies.

One of the most interesting statistics to come out of the studies undertaken relates to the attempt to get some form of help. The Battered Elder Syndrome indicates that in 95% of the cases studied an attempt by abuser or victim was made to obtain some sort of service. Social service agencies were most often contacted. This fact may point to the poor communication skills of the abuser and/or the victim. After a failed attempt at reaching other family members or a service provider, the abuser or victim may give up further attempts.

Two scenarios describing abusive situations follow. They are offered in order to help workers understand the dynamics which may lead to instances of psychological and physical abuse and neglect.

Scenario 1: Imagine you are a middle-aged woman who has built up her meager reserves of self confidence to find a job. The kids are grown and gone, leaving an emptiness in your life. You look forward to office work and the friendship and communication associated with the non-home environment.

After your mother has an operation, it becomes apparent that she can no longer care for herself. She comes to stay with you and all plans for work are scrapped. Your self-confidence slowly ebbs. You reach out to the community for in-home services. You find they are only for low-income persons. Your mother is ineligible because she is living in your home.

You feel betrayed, seeing your work plans crumble. You begin to spend more time away from home in order to avoid your mother. You know she needs many types of care, but you cannot face life as a caretaker. At times you let her go for days without a bath. You serve her poorly prepared meals and abruptly leave the room without offering conversation. You know this is cruel punishment for your mother but you can't help yourself.

Scenario 2: Suppose you are a middle-aged bachelor son. Mother, an 84-year-old woman in failing health, comes to stay. She has a small pension which provides for in-home care services such as washing, feeding, etc.

After losing your job, you resolve to live on the pension with Mom. All outside services are dropped as you feel you can care adequately for her. At the same time, you blame her for your failure to marry and to make a separate life for yourself. Now her presence disrupts your social life. Her attempts to communicate her needs to you seem like whining, and you criticize your mother for her ungratefulness.

Abuse somehow occurs. First as a slap on the cheek when Mom won't eat fast enough. You continue the slapping at mealtimes, saying to yourself that Mother needs discipline for her childishness. As the abuse continues, you build up a justification for continuing the abuse.

Asking a social service agency for help is unthinkable. It would be embarrassing and humiliating to have a social worker type of person in your home.

You are also frightened by legal intervention which might cause your mother to be moved, along with her pension. You might even go to jail.

HOW CASES COME TO LIGHT

There is evidence that victims and perpetrators of abuse rarely seek outside help or support specifically for abuse. In fact, the Massachusetts study found that in at least 70 percent of the abuse cases cited, the active involvement of a third person (someone other than the victim and his/her family) was required before the case was brought to the attention of concerned professionals and paraprofessionals. This suggests the need for some form of outside, third-party observation as a means of identifying abuse cases.

On the other hand, as pointed out earlier. The Battered and Elder Syndrome indicated that in 95% of the cases studies, either the victim or abuser requested assistance from an agency. Often the assistance was not provided. This finding suggests that most professionals and paraprofessionals are not attuned to the possibility of elder abuse, regard intra-family violence as a private family matter, or believe (rightly or wrongly) that reporting the problem is a breach of professional confidentiality. A great deal more education and training is needed to prepare workers to recognize and respond to what are apparently indirect cries for help.

Case of abuse come to light in various ways. An alert neighbor or friend may call adult protective services or the police. Visiting nurses, homecare providers, court investigators and others who go directly into the home to care for or monitor the elderly client are in the best position to identify possible forms of abuse and neglect.

A few states have established elder abuse mandatory reporting laws (MRL) which provide for immediate investigation upon receipt of an abuse report. In effect, these laws charge professionals who come into contact with older persons to become more aware of possible abuse and to guarantee that reported cases are dealt with in a responsible way by an established authority.

WHO GENERALLY REPORTS ABUSE?

Frequently, professionals are called into situations of alleged or real abuse. Health care professionals provide the most expertise in evaluating physical signs of abuse and neglect. Often the only time to detect abuse will be during a visit to the victim's home.

The studies on elderly abuse point out that visiting nurses, home services staff, medical social workers, probation officers, hospital social services directors, and home/health aide staff report relatively high rates of elderly abuse.

The Massachusetts Study indicates that emergency room supervisors, police, and regional welfare protective services managers produce the lowest rates of citings. All three groups, especially emergency room supervisors, are presumably in a position to identify more cases.

INTERVIEWING THE VICTIM

The victim may range from someone only too willing to discuss the abuse and seek an end to it to someone who denies anything is wrong. In addition to outright denial, problems the worker may encounter from the victim during an initial or subsequent interview include:

uncertainty over the worker's role, purpose, or attitude
unwillingness to authorize affirmative steps
reluctance to be specific
indecision
ambivalence about the problem and/or the abuser
fear of retaliation
double messages or frequent changes in basic decisions
confusion (from fear, drugs, psychological withdrawal, etc.)
irritability
non-responsiveness to answers

The worker should try to locate the source of the problem. Is a family member listening in? Has the worker adequately explained his or her purpose? Is the client in pain, under sedation, embarrassed about lack of cleanliness? Can the problem be solved or minimized?

In evaluating the victim's circumstances, the worker should be aware that sustained abuse, significant physical disability, or repeated failures to succeed in obtaining help can lead to learned helplessness. The victim may have been conditioned into believing that she/he is more helpless or vulnerable than in fact is the case. The worker may have to provide a great deal of support and encouragement to counter this problem. The worker should also be aware of the role his/her own emotions and attitudes may play in the interview and throughout the case-handling process. The worker should avoid casting blame or making harsh moral judgments. Even if these are not articulated, they may be communicated non-verbally.

The worker should also avoid the rescue syndrome. Most solutions to abuse or neglect will only be partially adequate and will take take time to achieve. The dependency needs of a victim and/or family cannot all be met by the worker. The worker must have the patience and strength to deal thoughtfully and carefully with what may be a repulsive, depressing, or frightening situation. The worker should attempt some sort of realistic self evaluation before handling such cases. Not everyone is equipped to manage a case with the necessary detachment, and most cannot handle many cases over a sustained period of time.

The following are some general guidelines on interviewing techniques that have been found successful in abuse and neglect cases.

GENERAL INTERVIEWING TECHNIQUES

Most of what a worker learns about client problems comes through interviews with that client, or with others who may have significant information. Interviewing them is one of the most important skills for any helping professional. One social work theorist noted that it is as important for a caseworker to practice interviewing as it is for a musician to practice scales. Learning to interview means quite literally learning communication, not just verbal interactions. The interviewer must try to remain aware not only of the work content of a client's comments but the accompanying emotional and physical content as well. Eye contact, body language and vocal pitch all play a role in developing the interview as a data gathering/data synthesizing situation. While excellence only comes with experience, there are some points which may be helpful.

Privacy: Every client has a right to privacy in the interview. This may be especially true for victimized elders since there is a tendency to infantilize dependent people who are under stress. Try to avoid interviews with audiences, even trusted friends or homemakers. There are obviously exceptions, but these should occur at the client's urging and they should be accompanied by some discussion about what it means to "open" an interview to others. Every client wants to believe that s/he is being taken seriously and privacy is a hallmark of "seriousness" in our society. If you can offer your client nothing else, you can at least offer total privacy and strict confidentiality.

Pacing: Athletes pace themselves for the total probable length of an event; interviewers should do likewise. Once you've determined approximately how long an interview should take, try to develop a schedule that not only accomplishes your goal, but which recognizes your client's needs as well. In cases of chronic abuse or neglect it is essential that the client feel that s/he has the right to react, ventilate etc. For example, if you must tell a client that his/her daughter has threatened you and has refused you access on two occasions, do so in the first or second third of the interview. The remaining time should be allotted to the client's needs and feelings, even if they are likely to be highly emotional.

Planning: Just as the worker develops an overall caseplan, s/he should give some thought to the individual interview plan. What is it that you want to accomplish with your client? How should the interview proceed in order to achieve this goal? Is this a goal which your client shares and understands? What if your client has his/her own agenda? It pays to be flexible, but not so flexible that interviews are haphazard and aimless.

Pitch: Virtually everyone responds to the pitch and tone of another person's voice. People react to this, sometimes without knowing it. Clients under the stress of an abusive or exploitive situation may be sufficiently regressed that *how* you say things is as important as *what* you say. Try to keep your voice well modulated and low. Try not to sound excited or shocked. Your feelings should not get in the way of your client's time for free expression.

Punctuality: Many clients already have negative feelings about interaction with social service staff. There is no need to risk engendering or increasing resentment because of delay. Always be on time for appointments. Keep to agreed upon schedules for service delivery.

SOME SPECIFIC INTERVIEW TECHNIQUES

Questioning: In order to get answers, questions must be asked; however, interview questions can be framed in at least two very different ways. For example, family information can be elicited in each of the following:

Directly: How many brothers and sisters do you have?

Non-Directly: Could you tell me something about your family?

The direct question, it's true, will elicit the simple piece of data you want. The non-directive question, though, will not only give you the "facts", it may well give you some "feelings" as well. The non-directive question can be especially useful with clients who are reticent about talking.

Many workers routinely open all interviews with a non-directive question of limited relevance such as, "How have things been going since the last time we got together?" Presumably the worker already has some agenda for the interview and a non-directive opening may allow the client to raise his/her concerns. The best approach is one which balances directive and non-directive questions.

Another method of questioning a client is the "one word lead". If a client makes a statement that is unclear, unfinished or ambiguous, this technique may be useful. For example, if your client says, "Yes, all the children turned out fine except for Dottie. . . .," you might simply respond, "Dottie?" Such a response asks for more information about the relationship without offering any particular boundaries. This technique can be very useful with older persons who are able to reminisce. Even with clients who tend to wander, the one word lead can be a tool to help focus.

Silence: Whether it's golden or not, silence can work to the interviewer's advantage. Most people are made sufficiently uneasy by silence that they will plunge ahead verbally to bridge the pause. If the interview has begun at all and seems to be moving in the desired direction, then silence from the interviewer can be quite valuable. As a general rule, no silence should run beyond five minutes. If the silence seems destined to continue, the worker might say, "Perhaps this isn't a good time to talk . . . would you like to set up another appointment?" Leave the decision to terminate a silence in your client's hands.

Finishing a client's sentence is one of the most common worker responses to short silence after an incomplete statement. Regardless of how difficult it is to avoid doing so, do not complete your client's sentence. Even if the client has a serious speech or motor-neural disability, s/he deserves the time it will take to listen and to listen carefully. If the incomplete statement is that important, consider a one-word lead or simply ask your client to complete the comment.

Emotion Modeling: For those clients who are especially passive or who seem ambivalent about emotion, "modeling" may be both a useful short-term technique as well as a productive long-term strategy. Emotion modeling allows the worker to suggest an appropriate emotional response to his/her client. For example, if a client says with little or no apparent emotion, "My husband left me . . . with three kids and it was the middle of the Depression . . .", the worker might reply, "That must have made you very angry." In general, choose emotions which are active and assertive, particularly for those clients who may need support in expressing something other than a passive response. Emotion modeling can be valuable, too, in situations where the client admits abuse or exploitation but is ambivalent about taking action. For example, the worker might employ this gambit, "Look, Mrs. Emerson, you've been a fighter all your life, this is certainly no time to give up." Emotion modeling must be used in the context of an on-going relationship, otherwise it can degenerate into a pep-talk attitude of questionable professionalism.

There are some cautions about modeling. Clients who are psychiatrically disabled and experiencing "flattened affect" (e.g., schizophrenics and depressives) probably won't respond. Similarly, organic brain damage clients will require other, longer term methods. If you have questions, seek a consultation. Try to find a mental health professional with geriatric/diagnostic skills. A good differential diagnosis can save you lots of time and energy.

(The following list of rights and principles is excerpted from Contemporary Social Work, Donald Brieland, et al, authors.)

Client's Needs and Rights	*Principles for the Worker*
(1) To be treated as an individual	Individualization
(2) To express feelings	Purposeful expression of feelings
(3) To get sympathetic response to problems	Controlled emotional environment
(4) To be recognized as a person	Acceptance
(5) Not to be judged	Non-judgmental attitude
(6) To make personal choice and decisions	Client self-determination
(7) To keep secrets about her/himself	Confidentiality

Closing the Interview: Always close your interview with a clear and explicit indication of what happens next. Another appointment? More information? Particularly in abuse cases, your client may be so anxiety-ridden that short-term memory has begun to fail. Remember that you are more familiar with agency routine than s/he is. Relief and resettlement workers in disasters must listen to essentially the same story over and over again. Despite that, though, it's a new story and a new routine for each of the clients. Part of a well-planned interview will be a thoughtful and orderly termination.[4]

CASE ASSESSMENT PROCEDURES

Followong the initial investigation, it is necessary to make an assessment of whether or not abuse or neglect exists in the case.

Suggestions for Assessment Techniques

Assessment, not unlike interviewing, depends upon striking a balance between directive and non-directive approaches. Some of the most valuable material may be elicited simply by looking and listening. For example, some issues about gait, dress and hearing acuity can be resolved simply by observing the client in the home. Similarly, cigarette burns in clothing or furniture may be indications of potentially hazardous behaviors. Sometimes merely watching a client try to locate a Medicare card will give useful insight into problem-solving ability.

Assessment Cautions

Certainly all social service interactions should be free of personal judgments; however, protective services assessments in the area of abuse and neglect in particular should be non-judgmental and problem-focused. Remember, the first concern of protective services is whether harm is imminent or occurring. It may be useful to know that a client sleeps on a mattress without bedding or lives in a house which has unmistakable odors; however, the major question is whether or not those things are likely to harm the client.

Intervention strategies are hard enough to implement; use them only when necessary. If uncertainty exists, maintain confidentiality but consult another worker. This is especially true when actively considering more restrictive alternatives such as guardianship or civil commitment. Assessment teams are most useful with these "restrictive" cases because the team approach adds other perceptions to the evaluation process. If formal team structure exceeds the resources of an area, consider assembling an informal "consultation" team by telephone. This approach was adopted by one social worker involved in a dozen guardianship cases because she wanted outside opinions about her assessments.

Finally, assessing a client, particularly a potentially abused or neglected client, requires patience and practice. The assessment is only as good as the person using it. Whatever evaluation form is used, be familiar with it. Practice assessing client capabilities with co-workers. Rely on descriptions of behavior ("client raises herself from chair using right arm for support") rather than comments ("client is paranoid"), unless you give specific description supporting the diagnostic term ("client says family hates her . . . sister has phone tapped . . ."). In general, be wary of any label—psychiatric or otherwise. Never trust your memory. Write your assessment notes as soon after the interview as possible.

---

[4] Some of the material in this section was drawn from Contemporary Social Work. cf. supra and from A Primer of Social Casework, Elizabeth Nicholds.

If the evaluation seems uneven or leaves areas untouched, make a list of points requiring clarification. Develop a strategy for eliciting that information and return to the client for another appointment.

Because of their compelling situations, potentially abused or neglected clients sometimes will not give a worker or an agency a "second chance". If the client does not feel that the case plan really addresses his or her needs, the client may well discharge the worker. A good assessment can begin establishing the kind of relationship which will diminish the likelihood of such occurrences. The assessment instrument at the end of this chapter is used by the State of Connecticut and is offered as an example others may wish to adapt for use in their own communities.

Remember, the case assessment is the culmination of the initial investigative stage of an abuse or neglect case. At the end of the assessment the worker should know whether or not abuse or neglect is occurring and, if so, whether or not the risk is serious enough to warrant immediate intervention. General situations calling for immediate action include:

maltreatment that could result in permanent damage to the victim.
the client is in an immediate need of medical and/or psychological care.
existing damage to the client is so extensive that he or she needs an immediate change in environment to recuperate.
the abusing or neglecting party is so incapacitated that he or she is unable to care for the client's basic needs.

CASE REFERRAL

For those unable to handle abuse or neglect cases themselves, referral to social service agencies is a frequent form of intervention. Agencies to which cases are most often referred include:

mental health clinics
in-home care providers
hospital social service departments
family service agencies
visiting nurses associations
public welfare departments
legal services programs

Referral may or may not result in a serious effort to address a problem, depending on the focus of the agency and its resources. In general abuse and neglect cases require a case manager and a case plan. The referring party should be aware of this fact. Too often the referral is just another form of neglect. The Battered Elder Syndrome indicated that in 95 percent of the abuse and neglect cases reported the victim or the abuser requested some form of help that was not provided. Follow-up by the referring party is a procedure owed a client, particularly one as vulnerable as a neglected or abused older person.

TIPS ON CASE MANAGEMENT AND CASE PLANNING

If the assessment reveals abuse or neglect, it is necessary to develop a case plan for the client and a procedure for managing that plan unless the client rejects all forms of assistance. The plan and the implementation of the plan will vary greatly depending on the client's situation, the worker's role, and the resources available. Homemaker services or a meals program may be enough to reduce the burden on the caretaker and solve the problem. At the other end of the spectrum, placement in an institution such as a nursing home may be the only realistic solution.

In general the case manager's role falls into four areas of activity:

1. Problem identification and review of the client's assessment
2. Case planning and referral
3. Service facilitation
4. Follow up

The case manager must review the client assessment or make the initial client assessment depending upon when he or she receives the case. After assessment the case manager must develop a comprehensive case plan with necessary referrals. As part of this process the manager should identify the client's problems; inventory the community's resources; and match community resources with client needs. This is easier than it sounds in abuse and neglect cases. As a rule, they demand innovative solutions. And as with any kind of case planning, knowledge of community resources is most valuable. For example, a worker confronted by a retired, disabled serviceman who is almost certainly being exploited by a family member will not have any particular community resource as a referral. She/he might, however, try to introduce the client to an assertive, alert retired serviceman recruited for "friendly visiting" from the local Disabled American Veterans post. The more assertive man might be able to assist the exploited client better than the assigned case worker, at least initially. Unless a client is willing to admit that she/he has been victimized, case planning which directly deals with the abuse or exploitation is probably less useful. Finally, case planning is rarely a "one shot deal". It is an ongoing process which should involve the client in key decisions.

The case manager's role as service facilitator is largely one of coordination. Referrals most often go away (especially in compelling abuse cases) because roles and responsibilities of various service providers are not clear. Few cases can assume such tragic proportions as those that end with an angry and confused client dismissing everyone because he or she feels lost in a field of competing "helpers". Make certain the client understands what services are being brought in and why. Try to involve the family to the extent possible. For clients with less ability to understand, the case manager must depend on the quality of his or her ongoing relationship with the client.

Follow-up may well be one of the most important roles a case manager can fill. Without follow-up, the clients can and do fall through the cracks of the best intentioned system. Set follow-up goals for each referral and let both the client and the service provider know what those goals are. A follow-up of this sort not only insures service for the client, it shapes the response capacity of service providers. Follow-up is a crucial element in abuse cases because it is an excellent way of demonstrating unfailing interest in the client's problem. It is essential to remember that case management follow-up will almost always have two distinct goals:

1. Service follow-up
2. Relationship follow-up

Because case management tends to focus mostly on securing and monitoring services, it is worthwhile to consider two increasingly accepted concepts about domestic abuse:

a. Persons abused, regardless of age, gender, race or economic status, tend to be "other excluding." They are not just isolated and alienated, but in some instances they work at being isolated.

b. The intervention strategy which seems most effective over time is one which uses a relationship rather than intensive counseling.

The implications of this for case managers is clear. In cases of victimized elders, an ongoing semi-therapeutic relationship may have greater long-term benefits than any specific service. This relationship need not be the full responsibility of the case manager and it is possible that such relationships might follow from case management referrals to other providers.

PLACEMENT OUTSIDE THE HOME

In The Massachusetts Survey, the single remedial action most often taken or recommended was placement in a nursing home, hospital, temporary housing situation, or mental health facility. In cases of emergency, removal of the victim from the home was recommended 50% of the time. However, there is no clear evidence that less restrictive alternatives were carefully explored. Placement may end the abuse or neglect but run counter to the victim's wishes and best interests. The victim may prefer to stay with family members rather than live in the usually restrictive and sterile environment of an institution. Barring imminent threat of serious harm or the clear preference by the client to move, the worker should explore what a carefully designed package of services delivered to the home could do to ameliorate the problem before recommending removal and institutionalization. In many cases such a package can reduce the caretaker's stress below the level that is causing the abuse or neglect.

The worker should also be aware of a number of alternatives to traditional institutionalization that are being developed. These include:

day care to relieve the stress on both the victim and the caretaker.

respite care (temporary overnight shelters) to provide a cessation of abuse or neglect and to allow for a cooling-off period and safe evaluation.

foster care to provide a "new family" context comparable to that available to abused children.

Unfortunately these services are usually unavailable. Those considering effective programs in the area of elder abuse and neglect should give careful consideration to establishing and providing such services.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
Protective Services for the Elderly

CLIENT EVALUATION AND FUNCTIONING

Client's Name ____________ Age ______ Sex ______

Client's Address ____________ Race ______

---------PHYSICAL ENVIRONMENT---------

Neighborhood: ____________

Shelter: Sound____ Deteriorating____ Dilapidated____ Water____

Electricity____ Heat____ Toilet____ Food____ Stove____

Housekeeping: ____________

Hazards: ____________

Other observations: ____________

---------SOCIAL ENVIRONMENT---------

Isolated____ Known and visited by neighbors____ Relatives____

Household composition: ____________

---------PERSONAL APPEARANCE---------

Dress: ____________

Gait: ____________

Posture: ____________

Facial Expressions: ____________

Gestures: ____________

Speech: ____________

---------PHYSICAL HEALTH---------

Client-defined problems: ____________

[Indicate duration of problems:]

Malnourishment____________
Lumps____________
Persistent Cough____________
Severe Headaches____________
Vomiting____________
Change in bowel habits____________
Blood in urine____________
Vaginal bleeding____________

Open sores____________
Sudden weight loss____________
Severe chest pain____________
Shortness of breath____________
Dizziness____________
Vision impairment____________
Hearing impairment____________
Other____________

Most recent vist to doctor__________ Next medical appointment______

Recent medical problems:____________________________________

____

Medications____

Comments:____

____

MENTAL HEALTH

Client-defined problems:____________________________________

____

[Indicate duration of each problem:]

Loss of appetite__________
Insomnia__________
Feelings of worthlessness__________
Loss of interest__________
Hypochondria__________
Suspiciousness__________
Hallucinations__________

Delusions__________
Thought distortion__________
Confusion__________
Impaired judgment__________
Memory lapses/loss__________
Orientation__________
Other__________

Hazardous behaviors____

Alcohol or other drug use___________________________________

Recent losses of family or close friends____________________

Past mental health problems_________________________________

Capacity to consent____

Other comments:____

____

CLIENT MOBILITY

Bedridden__________
Partially bedridden__________
Wheelchair__________
Housebound__________
Able to get to yard__________
Neighborhood__________
Public transportation__________
Drives car__________
Other__________
Comments:__________
____

PHYSICAL COMPETENCE

Feeds self__________
Bathes self__________
Dresses self__________
Uses toilet__________
Gets out of bed__________
Light housework__________
Climbs stairs__________
Goes outdoors__________
Cooks__________
Shops__________
Heavy housework__________

----------------------ECONOMIC SITUATION----------------------

Income______________________ Resources______________________

Expenses____

Affairs managed by______________________________________

Comments____

OTHER HELPING PERSONS OR AGENCIES INVOLVED [specify involvement]:

CLIENT'S PERCEPTION OF PROBLEMS:______________________

WORKER'S PERCEPTION OF PROBLEMS [specify nature of protective problem]:

RECOMMENDED ACTION:______________________________

OBSTACLES: Does client consent?______________________
Is client's ability to consent questioned?______________
Other:______________________________________

EMERGENCY:______________________________________

Worker's Name

Date completed

I,______________________________, authorize the Department of Social Services to provide the services they may deem necessary to insure my safety. I agree to reimburse the Department if it is later determined that I am to pay for the services provided.

Witness's name **Applicant's name** **Date**

CHAPTER 5—LEGAL ISSUES AND REMEDIES

Cases of family violence raise fundamental and complex issue of privacy, confidentiality, access to the victim, protection of the victim from further harm; restraint, punishment or rehabilitation of the assailment; and possibly issues of the mental competency of both the victim and the abuser.

Most victims fail to report their plight or are unwilling recipients of assistance to prevent further harm. These client characteristics pose immediate and difficult legal and ethical issues for workers investigating and assessing cases of elder abuse. Two issues confronted initially are the client's right to privacy in the home and the client's right to have information about him/herself held confidential.

ACCESS TO THE ABUSE VICTIM

The question of access to persons living in private residences is a key issue for workers with clients who are suspected abuse victims. Under the laws of most states, there is no legal authority for a worker to gain access without the consent of the elderly person or the caretaker. Traditional trespass laws govern.

There have been many reports of elder abuse cases which raise the issue of access. Because this legal constraint at times causes difficulty in outreach and service provision, some social workers have come to rely on gaining access through homemakers, housing inspectors, or meal providers. Such intervention relies on deception and a betrayal of confidentiality and is inappropriate. It violates the individual's right to privacy and creates the potential of civil liability for the social service worker and his/her agency. In addition, it may destroy or prevent the development of any trust between the client and the workers.

There is often a conflict between the humane impulse to provide services and the individual's right to refuse services or even access. This conflict raises questions such as:

> Does a person have a right to remain in a dangerous environment if s/he wishes?
>
> Must s/he be left exploited or neglected, even to the point of starvation, if s/he chooses?

The following is a brief analysis of issue raised by this conflict.

First: Basic to our legal system are the individual's right of self-determination and right to privacy. These constitutional rights are an expression of the sanctity of individual free choice as a fundamental constituent of life.

The individual's civil rights are not absolute or without limit. The state (and its agencies) can and does intervene, regulate, and prohibit. State intervention occurs pursuant to two legal doctrines:

> *Police power*, which gives the state authority to regulate activities that involve the health and safety of society.
>
> *Parens patriae*, which gives the state authority to act in a parental capacity for persons who cannot care for themselves or who are dangerous to themselves.

Intervention by the state is regulated by balancing the state's interests (under the police power or *parens patriae* doctrines) against the interests of the individual to be left alone. In child abuse reporting statutes, the states can intervene in the life of a family because it has an overriding interest in the health and welfare of the child.

The parameters of state intervention are often unclear, reflecting historical and social trends. When the state does have the right to intervene in individual lives (under health regulations, social welfare laws, etc.), that right is defined specifically by statute and regulations. The state does not have the right to intervene in a person's life without either the person's consent or statutory authority. Such limitations on state intervention serve to protect those individual righs we value.

Second: The competent person has the right to refuse social and medical services:

> The highest court of Massachusetts held in *Lane* v. *Candura* (1978) that, if an elderly woman was competent, she could make her own decision concerning the refusal of "needed" medical treatment, whether or not that decision might seem irrational to others. The court found that Mrs. Candura was competent. The evidence showed that she tended to be stubborn, that she was lucid on some matters and confused on others, that her train of thought wandered, that her conception of time was distorted, that she was sometimes hostile, occasionally defensive, and sometimes combative to questioning, but that she had a high degree of awareness and acuity. The court said that irrational did not mean incompetent.

The right to refused services can be limited if the individual is found to be legally incompetent. Under most state laws, limitations on the individual's right to self-determination require the state to present sufficient evidence to meet the statutory criteria for appointment of a guardian (i.e., the individual is unable to care for his/her basic needs or to make responsible decisions concerning him/herself) or for civil commitment to a mental health facility. Such determinations are only allowable with full due process protections, including the right to counsel.

In a judicial determination of the individual's competence, the court relies on evidence, testimony, the persuasiveness of argument by the attorneys, and other, often intangible, factors such as the inability to think or act for oneself as to personal health, safety, and general welfare, or to make informed decisions as to property, finances, etc.

While state guardianship statutory standards may be similar (many states use the Uniform Probate Code), case law interpreting the standards varies from state to state, and in some instances from community to community. Recent cases have addressed whether one who is "insane" but able to care for basic needs such as food, clothing, and shelter can be forced to have a guardian. At least one state Supreme Court has denied guardianship in such a case. Whether the same reasoning would apply in other states or in a case where someone chooses to remain in an abusive environment is unknown. It is clear that the "competent" (i.e., non-insane, able to care for onself) individual can make an irrational decision to remain in an abusive enviroment.

Third: The authority to intervene when services are refused is limited.

If services are refused, a social services agency has no legal right to intervene without a showing of incompetence.

Even if the individual can be proved incompetent under the often vague standards of state law, a person willing to be a guardian must be located. Finding such a person is often difficult. Some states do have an Office of Public Guardian to deal with such cases.

If access to the home is denied, access cannot be gained unless there is an emergency (a fire, someone calling for help, etc.). In some cases (e.g., a health inspection), a warrant or other court order is necessary.

In a suspected abuse case where the apparent victim has not complained and access is denied, no legal action can be taken without evidence and/or a witness. If there is substantial evidence and/or a witness, a criminal complaint is a possible—but not necessarily good—alternative.

Fourth: Many states have recently enacted adult protective services statutes that make reporting adult abuse mandatory.

Despite these laws, intervention is still prohibited if the elderly person refuses services. In some states, broad powers to provide services to involuntary clients are set out. The standards and procedures of these laws vary from state to state and, in some cases, pose significant threats to the civil liberties of the elderly.

CONFIDENTIALITY OF CLIENT INFORMATION

A second fundamental aspect of the right of privacy is the client's right to confidentiality concerning anything the worker learns about the client's situation.

Federal law and many state laws now prohibit the divulging of information obtained from a client which would serve to identify that client. These statutes and regulations require that a social service agency seek and obtain the consent of the individual before making a referral, discussing a case with other agency staff, or instituting a case plan.

The client's right to privacy of information concerning his/her case is now defined by statutes and regulations which vary from state to state. Protected information generally includes any data contained in case files or computer files, including information concerning the client's medical, social, psychological, financial, and vocational situation.

Most states require that before this information may be released by the client's worker to anyone other than the worker's supervisor, the client must give informed consent for its release. Such consent, to be informed, requires that the client be informed as to what information is to be released, to whom, for what purposes, and with what possible consequences. The client must receive this information in a form comprehensible to him/her and must indicate clear understanding and agreement. Such consent must be overt, i.e., a clear statement given verbally or, preferably, in writing—it cannot simply be implied.

Most states now provide fines and/or jail penalties for unauthorized release of confidential information. In addition, a client in most states has a right to sue for damages for unauthorized release of confidential information.

Privacy rights are easy for workers to adhere to in the abstract. In practice, workers must exercise real restraint in conducting case assessments and doing fact-gathering if they are not to violate the client's rights to privacy and confidentiality. The laws clearly mean that a client has a right to determine with whom a worker discusses the case. While such a requirement may seem inhibiting to some workers, most workers agree that good casework requires trust between client and worker, and that privacy and confidentiality laws are supportive of developing and maintaining such trust. Disregard of client rights should not be rationalized by any notion of working in the "best interests" of the client.

CRIMINAL COURT REMEDIES

Abuse of an elderly person constitutes a crime. Depending on the facts, an elderly person who has been physically abused or exploited can file a complaint charging assault, assault and battery, assault and battery with a dangerous weapon, blackmail, extortion, etc. One must ask whether reliance on the criminal justice process is an effective approach in most cases of elder abuse.

The criminal justice system requires that the elderly victim be willing not only to file a complaint with the district attorney, but also to testify in court. One of the clear findings in the research done on elder abuse is that victims are most often harmed by family members. There is further evidence that victims often do not want to get the family member in trouble and therefore are unwilling to use the criminal justice process.

The disposition of a criminal complaint involving domestic violence depends upon the facts of the case. The variables examined include the extent of the injuries, whether this is a first offense, who the parties are, who the judge is, the testimony of the victim, the objectives of the district attorney, mitigating circumstances, etc.

Experience in spouse abuse cases indicates that many criminal trial court judges, relatively less experienced and less sympathetic to domestic matters traditionally handled by domestic and probate courts, prefer to rely on reconciliation as a solution to abuse, rather than to use the power of a criminal court to "protect" the victim by imposing criminal sanctions. The judges often believe that such sanctions will destroy a family that otherwise might be saved. Even in cases where criminal sanctions are appropriate, some judges may consider the expenses society will have to bear to sustain a dependent adult outside the home and push reconciliation instead, leaving the victim more at risk than ever.

In general, judges adopt a lenient attitude toward the defendant in a criminal case where the injury is not extreme or is a first offense. Thus, quite soon after filing a complaint, the abuser will probably be released—either outright or on probation. One can speculate that the abuser will then return home to the elderly person. The increased antagonism may well cause another incident of abuse. Because a protective order is not issued in conjunction with the criminal justice process, the elderly person has no form of immediate protection upon which to rely other than the inadaquate choice of reporting a probation violation or filing another complaint with the district attorney. The probation process cannot serve to assure the elder's physical safety because it does not call for police enforcement or protection. Let it not be misunderstood that protective orders issued from civil courts are necessarily effective or even enforced. The incidence of police non-response is well-known. But in order for this to change, utilization of such orders and insistence on their enforcement is needed.

In cases of extreme violence and injury, a criminal complaint may result in a long prison sentence. Clearly, this removes the abuser from the household. But, again, this remedy is not linked to providing a substitute for the caretaker/abuser. Nor is there linkage with service provision necessary to assure the welfare and potential self-sufficiency of the individual. Thus, the criminal justice system, functioning in isolation from service provision, inevitably fails to correct the underlying causes or to provide protection and support services most essential to the person in need.

In most states until the 1970s, restraining orders were not available for cases of domestic violence unless a divorce or separation petition had been filed. This remains true in some states today.

Where this is the situation, civil relief for victims of elder abuse is virtually non-existent. Since most victims of elder abuse are not abused by spouses, a restraining order cannot be obtained because no divorce petition can be filed. Even if the spouse is the abuser, the victim may desire protection but not divorce.

As of July 1980, thirty-four states had enacted laws providing for the issuance of restraining orders against domestic abusers. The laws are usually referred to as Domestic Violence Acts or Adults Abuse Prevention Acts. Most of the statutes create new civil and sometimes criminal remedies for persons abused by family or household members. Some laws specify the powers and duties of police who answer domestic disturbance calls. Some require agencies offering services to violent families to keep records or write reports on family violence. Most importantly, many state legislatures have appropriated funds for shelters and other services to victims of violent families.

While the statutes vary, the following are characteristics of some of the currently operating domestic violence state laws:

> The law applies to abuse, not normally to neglect or exploitation.
>
> Abuse is generally defined as attempting to cause or causing physical harm, placing another in fear of imminent physical harm, or causing another to engage involuntarily in sexual relations by force, threat of force, or duress. (Definitions of abuse vary according to the state statutes.)
>
> Any child or adult may bring a court action against a household member, a spouse, a former spouse, or blood relative. Thus, an elderly person living with a family member or friend can use such a law, but the victim is the only person who can file—not a friend or agency worker.
>
> The action is initiated by a civil, not a criminal, complaint.
>
> The relief which may be obtained is a protective or restraining order against the abuser requiring that person to stop further abuse.
>
> In some states a vacate order may also be obtained which requires the abuser to move out of the house, regardless of who owns it or pays the rent.
>
> Violation of an order is contempt of court and therefore a criminal act. This subjects the abuser to arrest and a fine or jail term.
>
> Some states also require the abuser to pay for losses suffered by the victim as a result of the abuse. This may cover medical bills, moving expenses, loss of earnings, rent or mortgage payments, and attorneys' fees.
>
> Court filing fees, use of a lawyer, and complicated petitions have been eliminated in some states for persons filing actions for protective orders.
>
> In all but emergency cases, the victim/petitioner must give notice to the alleged abuser/defendant before a court hearing will be held on the matter.
>
> If there is immediate danger of abuse, or if notice will endanger the safety of the victim, the victim can seek an emergency temporary court order without giving prior notice to the abuser.
>
> Emergency petitions in some states will be heard by the courts within hours of being filed, 365 days a year, day or night.
>
> If an emergency order is issued, the defendant has an opportunity for a hearing to contest it within a few days.
>
> Many laws require police to take specific actions to prevent further abuse if the officer has reason to believe that the person has been abused or such abuse is imminent. This includes remaining on the scene until the danger has been eliminated, assisting the person to necessary medical care, giving notice of rights to the victim, and arresting the abuser in certain cases.

Lawyers and courts are intimidating and confusing. Often the elderly person will not agree to seek a legal remedy. If the victim is willing to go to court, the remedies available through the judicial process are often inadequate. Removing the caretaker from the home does not necessarily make the social service system able and willing to compensate for the lost support and assistance. Shelters which have been established to provide alternative housing for abuse victims often cannot meet the needs of the disabled or more dependent elder.

The difficulty with the statutes, then, usually lies with the lack of a mandated in-home supportive services system necessary to supplement or replace the caretaker for elderly abuse victims. State legislatures should be made to realize that dependent, vulnerable elders may be seeking remedies under these laws and that they have special service needs.

Those thirty-four States that already have domestic violence statutes should evaluate their resources and consider mandating programs that specifically provide the needed services. States without domestic violence statutes should consider enacting statutes that include provisions establishing the necessary in-home and other supportive services.

Even with their limitations, domestic violence laws have opened up new possibilities for an elderly person who is able to make the necessary decision to seek protective orders.

PROTECTIVE OR SURROGATE REMEDIES

A frequent mistake in the handling of elder abuse or exploitation cases occurs when workers encounter a competent victim who will not consent to take action to prevent further harm to him/herself. Workers frequently conclude that refusal to accept assistance is a sign of irrational behavior which requires appointment of a guardian or other surrogate to care for that person. Adhering to the principle of the least restrictive alternative, workers should analyze the client's incapacity by first asking the following questions:

Is the incapacity something that could be alleviated by medical attention?

Can the incapacity be compensated for by support, advice, assistance from supportive services available in the community?

What is the least restrictive alternative? Each person has the right of self-determination. Any limitation of that right should be the minimum necessary. Guardianship reduces the elder to a legal status comparable to that of a child.

The following alternatives to guardianship may be appropriate, depending on the facts of the situation. The alternatives are listed in order of increasing formality and loss of control by the person subjected to them.

Direct Deposit. Federal benefits (Social Security, SSI, VA, etc.) can be deposited into the client's bank account directly. This simple mechanism may prevent theft of checks. This arrangement is set up by the client and bank.

Joint Bank Account. No court order or other proceeding is required. Both parties simply sign authorization cards for the bank. Either party has the legal right to the entire contents of the account.

Restricted Bank Account. These include co-signatory accounts requiring two signatures for withdrawal and accounts with permanent withdrawal orders (i.e., the bank issues a monthly allowance to the individual).

Power of Attorney. No court proceeding is required. Written authority is generally necessary. This device confers power to another to sign documents and act on behalf of the elderly person, a power terminated whenever the client wishes. It is best to include accounting provisions, termination date, and specific description of powers conferred. A power of attorney is usually automatically revoked by incompetency, mental illness, or death, except where "attorney" did not have actual knowledge and acted in good faith. One need not be a lawyer to receive power of attorney.

Representative (Substitute) Payee for Social Security. Social Security regulations (20 C.F.R. 404 §§ 1601 et seq.) provide a mechanism for another person to receive a beneficiary's check. The standards are very loose ("in the best interests of the beneficiary . . .") for such an appointment. The beneficiary can request that a representative be appointed. The representative payee must use the money solely in the interest of the beneficiary and must take periodic accounting to the Social Security Administration. Similar provisions exist for handling federal Veterans benefits and for Supplemental Security Income.

Each of these options has disadvantages as well as advantages. Each can help solve a problem, or, when the wrong person is involved, create an opportunity for financial exploitation. Legal assistance should generally be sought in setting up one of the money-management devices, and always in any case of suspected exploitation.

When none of these options will remedy the problem, then conservatorship, guardianship, and civil commitment must be considered.

Conservatorship. A conservator is appointed by a probate court judge after a hearing. Most state conservatorship laws state that a conservator can be appointed if a person is unable to properly care for his/her property due to advanced age, mental weakness, or other disability. This is an appropriate remedy in a case of exploitation if the victim lacks the *capacity* to manage his/her property. Note that the financial management services discussed above can be utilized only when the victim possesses the capacity to manage property. A conservator generally receives control over the person's property and finances, not over other areas of the person's life.

In many cases of abuse, financial difficulties and conflict may be a major source of stress. Removing this stress by placing financial control in the hands of uninvolved persons may result in dissipating the potential for abuse. There are a number of reported cases in which a relative was appointed conservator and proceeded to divert funds to his/her own use.

Guardianship. A guardianship is also appointed after a hearing in probate court. At the hearing, it generally must be established that the proposed "ward" is incapable of taking care of his/her basic needs due to mental illness or other disability. If this is established, usually through medical or psychiatric testimony, the court declares the person to be legally incompetent and the guardian assumes control of his/her personal affairs. In many cases the guardian will also be appointed as conservator—that is, controller of the ward's financial affairs. Where the ward has a small estate, guardianship itself implies some control over the ward's finances to the extent necessary to meet his/her basic needs.

Guardianship is a drastic remedy in that it almost completely removes the ward's right to self-determination and autonomy. In most states, a guardian can place the ward in a nursing home against the ward's wishes.

Guardianship is appropriate only if the individual is totally unable to care for him/herself or cannot make responsible decisions concerning his/her life and welfare. As a remedy for abuse, it allows another person with surrogate authority to remove the ward from an abusive environment or to file an abuse prevention petition on the ward's behalf.

Appointment of a guardian rarely constitutes the least restrictive legal device for most persons in need of protective services. Social Service agencies often encourage guardianships as a means of "giving" services that the elderly person refuses to accept. Thus, it can be a tool to enforce the social service agency's notions of the "best interests" of the client. In such a case, competency and ability to care for oneself are not the real issues. Often the courts rubberstamp a physician's opinion without a full and impartial hearing rigorously applying due process and other legal standards.

Civil Commitment. This is the judicial process by which a person is involuntarily placed in a mental institution. Civil commitment statutes generally require a finding that:

The individual is mentally ill;

The individual is dangerous to a degree such that failure to confine would create the likelihood of serious harm to the individual and/or to others; and

Commitment is the least restrictive alternative.

Civil commitment is the most drastic alternative and should only be used as a remedy in an abuse case where these three factors are proved beyond a reasonable doubt and where there is an indication that the person will receive treatment once s/he is committed.

The preceding sections of this chapter have discussed various legal issues and remedies in handling cases of elder abuse. Two points should be remembered:

Legal remedies by themselves are rarely sufficient.

They can make matters worse.

The law is a rough tool; legal remedies are often not appropriate remedies in cases of elder abuse. Sensitive social case work is more likely to succeed in most cases than is use of the law.

Finally, it should be noted that most of the laws discussed above vary from state to state. Anyone working in elder abuse should take the responsibility for finding out exactly what the relevant state statutes say. Usually, this means consulting a lawyer familiar with these areas of law.

CHAPTER 6—PROTOCOLS FOR HANDLING CASES

Two basic roadblocks which impede effective treatment of victims of elder abuse are:

The inability to gain access to and cooperation from victims.

A lack of medical, social service, mental health, and legal personnel trained to treat cases of elder abuse.

The first problem involves the victim's rights to privacy and self-determination, as well as the victim's possible ignorance about available remedies. The second involves the lack of preparedness by the community to help victims of elder abuse.

The first problem may or may not be solved, depending upon the victim's willingness to be helped. The second problem definitely can be solved. Solving the second problem is often essential to solving the first.

PURPOSES OF THE PROTOCOLS

The protocols introduced in this chapter have four purposes:

To serve as a pathway for workers to follow in handling individual cases of elder abuse.

To highlight the interagency and interdisciplinary cooperation which is needed in an effective community response system for handling elder abuse cases.

To provide a case management process to be followed in assessing, evaluating and developing a case plan for elder abuse cases.

To serve as models for other agencies to use in developing their own case protocols, e.g., hospital emergency rooms, visiting nurse associations, police departments, etc.

FOUR CATEGORIES OF ELDER ABUSE CASES

Individual victims of elder abuse are not susceptible to easy classification. The uniqueness and variety of the cases do not mean that there are no common characteristics. Legal Research and Services for the Elderly created four categories of elder abuses cases that have proved useful in understanding, assessing and planning for victims of elder abuse. These four client categories then served as the basis for developing case protocols.

These four basic client categories of elder abuse are:

1. *Competent, consenting client:* the client who appears to be mentally competent and who consents to assessment and assistance.
2. *Competent, non-consenting client:* the client who appears to be mentally competent and who may refuse assessment and does refuse assistance.
3. *Incompetent client:* the client who (regardless of his/her degree of cooperation) appears to lack sufficient mental capacity to make informed decisions concerning his/her own care.
4. *Emergency client:* the client who is in immediate danger of death or serious physical or mental harm, and who may or may not consent to help and may or may not be mentally competent.

These four categories have as their point of reference the client's right and ability to determine the system's response to his/her problems. The client's rights and wishes will bring the protective services system to a halt, time and time again, unless pre-planned responses are available for each client type.

Workers who have attended training sessions held by LRSE staff have often spoken of their feelings of helplessness when confronted with suspected victims of abuse who refused assessment and services. Concerns over protecting clients' rights in potential guardianship situations and questions about the proper use of legal representation for agency staff and clients in such situations were often expressed by workers. These problems can be lessened and in many cases solved if agencies have a list of steps and time frames which should be followed when workers are confronted with such situations.

CASE PROTOCOL FORMAT

The protocols follow the same basic format, as outlined below:

Type of client.
Characteristics of such a client.
Outline of case plan.
Initial case contact.
Initial case assessment.
Case evaluation and case plan development: general considerations.
Case evaluation and case plan development: specific considerations.

The protocols discuss social work techniques for assessing and handling cases. Legal issues concerning the particular type of victim are reviewed. Financial, housing and support services issues are also examined.

For purposes of this manual, the protocols do not refer to the laws of any specific state. Therefore, when dealing with a particular legal issue, a worker should seek legal counsel in his/her state.

CASE PROTOCOL NO. 1

Type of Client: Competent, consenting client.
Characteristics of client:

The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment. (These four are hereafter referred to generally as "victimization" and the term "abuser" will generally refer to persons responsible for any of the four types of victimization.)

The person is legally competent, and has not been adjudged incompetent by a court of law and/or has not had a full guardian appointed to oversee his/her life or assets. Nor has the client been committed to an institution by a court of law.

The person understands what has happened to him/her and desires to take action to halt further victimization.

OUTLINE OF A CASE PLAN

Initial Case Contact: A worker in a community agency receives a report of, or uncovers a case of suspected abuse, neglect, exploitation, or abandonment. This report will, in all likelihood, be from a third party and not from the victim.

Initial Case Assessment: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information and discuss methods for resolving the problem.

The worker should remember that the client has the right to reject any unwanted intrusions into his/her life and that this initial case assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that the initial assessment is a positive interaction.

If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that he/she wishes to proceed with the case before proceeding further.

The worker should also remember that the client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with other parties, the worker should request and receive permission to do so from the client (in writing, if possible).

If the worker has already determined that he/she will not be the primary worker on this case, then he/she should discuss this with the client and clearly indicate that another person will be contacting the client in the near future on this matter. This transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should thoroughly brief the new worker on the facts of the case and accompany the new worker on the first visit.

Information which the worker should attempt to elicit from the client at the initial meeting includes the following:

Health condition and name of client's doctor or primary health care facility.

Sources of income.

Family members.

The nature of the living arrangements, e.g., who owns home or who pays the rent.

Whether the person has friends nearby who might be available to provide assistance or support.

CASE EVALUATION AND CASE PLAN DEVELOPMENT: GENERAL CONSIDERATIONS

Case evaluation and case plan development follow a determination by the worker that the client is a victim of abuse, neglect, exploitation, or abandonment. This step may begin at the time of the initial case assessment described above, depending upon whether the worker initially involved in the case will handle it throughout or will be transferring the case to another (specialized) worker.

Case evaluation consists of a complete investigation and analysis. The development of a case plan is based upon this evaluation and may actually include the development of two or three potential plans which will be discussed with the client. These plans should be based upon the premise that there are likely to be a number of possible responses to actions taken by the client and worker and that contingency plans need to be available.

The case evaluation should, of course, be conducted by the primary worker on the case, probably the protective services worker if one is available. With the client's agreement, the worker should seek additional information concerning the client's problem from other persons who know the client. These persons might include other case workers, the client's physician, visiting nurse or mental health worker, senior center or nutrition site staff, and neighbors or friends. In addition, the worker may at this point wish to consult with a formal protective services committee which may have been established in the area in order to complete a thorough assessment of the client's status. This fact gathering and analysis process should provide the information needed to develop the case plan(s).

The development of a case plan, as indicated above, consists of a number of alternative courses of action which may be pursued with and on behalf of the client. In developing the case plan, the worker will probably want to draw upon the knowledge of the local protective services committee, if it exists, or, alternatively, may wish to consult with a physician, nurse or mental health worker, a lawyer, or another protective services worker.

If legal advice is sought, the worker should be certain to consult with an attorney who is not likely to be called upon to provide legal advice or representation to the client on the same problem at a later date. This is important because a lawyer may only represent one person in a given case, and the worker and client do not necessarily share the same interests at all times. Legal advice which the worker may require includes:

The definition of competency under the guardianship laws and whether the client appears to be competent under that definition.

How to petition for a guardianship or conservatorship.

Whether criminal acts have been committed.

Possible alternative legal methods of handling cases of financial exploitation.

The implications of using a domestic violence statute.

What the worker's liability may be in investigating the case.

Once case plan alternatives have been developed, the worker should again meet with the client (or talk on the telephone, if a meeting simply is not possible) to discuss the alternatives. This is obviously a critical point in the worker/client relationship. The worker needs to be especially supportive, sensitive, patient, and lucid in presenting alternatives and likely outcomes. The client's right to self-determination should be the primary consideration at this point. A clear agreement should be reached as to the next steps to be taken.

CASE EVALUATION AND CASE PLAN DEVELOPMENT: SPECIFIC CONSIDERATIONS

In conducting the case evaluation and developing case plan(s) for a competent, consenting client the following specific considerations need to be examined:

Existence of Victimization

The incident(s) of victimization needs to be verified and additional information obtained. Witnesses help but are not absolutely necessary if the client is competent and willing to act on his or her own behalf.

Competency of the Individual

If the client does not have a guardian or has not been legally committed to an institution and clearly can function in daily life without threat to him/herself, then the client is almost certainly competent. Therefore, use of guardianship or commitment procedures need not be considered by the worker as possible remedies for the victimization.

Some workers forget this in difficult cases and return to guardianship as a possible remedy because all other alternatives appear impossible. This is a rather self-defeating behavior on the worker's part.

The questions for the worker, then, are:

Is the victimization which has occurred the type of action for which civil or criminal relief may be sought with expectation of success?

If so, does the client/victim wish to make use of this remedy now?

If the answer is yes to the two previous questions, what precautions should be taken with the client before actually seeking the court's help—e.g., to make sure the client is not alone with the abuser when notification of the court action is given to the abuser?

What support services will the client need once the court order is obtained and the abuser is restrained and/or removed from the house?

Some clients will be ready to use legal action and may proceed with a lawyer. In most states there are elderly law projects, and the client may obtain free legal assistance from those programs.

If the client is not prepared to utilize legal remedies initially, two points should be remembered. First, only the victim can file complaints with the court; the worker or a friend cannot file the complaint on behalf of the victim.

Second, while the client may be unwilling to use this remedy initially, s/he may be willing to do so later. The worker may therefore wish to raise this possibility again at a later date.

If the client does wish to make use of a legal remedy, the worker, client, and the client's lawyer, if one is obtained, should develop a complete strategy. A decision should be made as to what relief to seek. Based upon that decision, plans should be made to assure the safety of the client prior to and immediately after the complaint is filed and the abuser receives notice.

These plans may include:

Arranging for temporary housing for the client.

Arranging for the worker or another person to stay with the client for a period of time.

Arranging for the client's lawyer or a police officer to be present to persuade the abuser that the court action is a serious matter.

Before seeking a court order, the worker, client, and client's lawyer should be confident that they can get the court to agree to issue the order and that they can arrange whatever services will be needed. This, again, may involve:

Locating temporary housing for the client.

A conversation between the client's lawyer and the abuser concerning the complaint.

Identification of additional emergency financial resources for the client.

FINANCIAL ISSUES

Money is a critical concern in most cases of elder victimization. Possible remedies for the problem may also include arranging for some financial protection for the client/victim.

Many cases of abuse appear to result from pressures and/or arguments over money. Some cases involve the abuser's financial problems which are exacerbated by having to support the older person for whom the abuser is the principal caretaker. Other cases involve an elder victim who is subjected to abuse because s/he refuses to turn over funds to the abuser.

Typical cases involve so-called "friends" or family members who steal or extort funds from the older person. These cases sometimes involve physical abuse as well as exploitation.

The facts of the specific case will determine what alternative financial plans are developed. Certain steps should be taken by workers in most cases of abuse and/or exploitation and in some cases of neglect and abandonment.

Investigation and Analysis of Client's Income and Assets

Asking persons about their incomes and assets is a touchy subject and a clear intrusion into the person's private affairs. Such inquiries must be handled sensitively, discreetly and with proper explanation to the client as to why the worker wants the information.

In cases where there is financial exploitation, the worker and client should attempt to make a complete listing of all current income sources (SSI, Social Security, pensions, interest or dividends, etc.).

The worker should find out:

When the income is delivered to the client.

To whom it is sent, e.g., is the SSI sent to the client or a representative payee?

What the current practice is for handling this income when it arrives, i.e., who cashes the checks.

Whether the money is deposited in a bank or not.

Whether the bank account is in the client's name.

Whether it is a joint bank account, and if so, with whom.

If someone handles the funds for the client, how the client obtains cash, and how the client gets an accounting of his/her assets.

Whether a conservator or guardian handles all money matters.

Who pays household bills normally and how.

It also makes sense for the worker to obtain information on the client's other assets. This might include the determination of:

Who owns the house in which the client resides.

What real estate the client owns and whether the real estate is solely or jointly owned.

Whether there are stocks or bonds and, if so, in whose name.

If there is a car, who is the listed owner.

Whether the client has other real property.

Whether the client has a safe deposit box and, if so, who has access to the box.

The above information may also be needed in certain cases of abuse and neglect in which a physical relocation of the client is likely. Financial information, if available, is also useful in solving cases of abandonment.

Most of the above information will be available from the client, but it may take a long time to develop a complete picture of the client's assets. A combination of direct questioning and careful notetaking during less directed conversations should produce much of the necessary data. The client's permission should be sought before others are contacted to fill in gaps in the client's financial history.

Case Planning Involving Financial Matters: When a Physical Move Is Necessary

Financial planning is critical in cases where the client may have to move to a new location. Planning should be designed to assure that the client does not lose income or assets as a result of the move, and that the client has sufficient funds to survive in the new location. The worker and client should take measures to assure that the following will occur:

Regular income, such as SSI, Social Security, pension checks, etc., is sent to the new residence of the client or is directly deposited in the client's bank account (this may take a number of weeks prior notice in some cases).

The client's portion of any bank account(s) is withdrawn and safely deposited elsewhere.

The client discusses with a lawyer or bank the steps that should be taken to protect any jointly held assets.

If the abuser/exploiter happens to be a representative or substitute payee, this designation is changed.

A list of valuable personal property belonging to the client is compiled prior to the move and that property is removed from the home with the client.

If the client has virtually no income or fluid financial assets, the worker should make certain that temporary and/or long-term financial assistance *is available at the time of the move.* This may mean seeking emergency aid from churches, the Salvation Army, private agencies such as Family Service Associations, Catholic charities, Jewish philanthropic agencies, or the welfare department.

Financial aid may be needed for temporary or long-term housing, groceries, clothing, and medicine. If the client is eligible for SSI, Medicaid, and/or food stamps and does not currently receive these benefits, applications should be filed (with the client's consent). Federally-funded public housing for eligible clients may also be explored for emergency shelter. [See section on Aternative Housing, below.]

When Financial Exploitation Exists

When financial exploitation has occurred, a criminal act has probably been committed. If the client agrees, a criminal complaint may be filed by the client with the District Attorney's office. If the evidence warrants it, the D.A. will file criminal charges against the exploiter and will attempt to recover the funds.

In certain situations the client may file a civil complaint against the exploiter and attempt to recover damages equivalent to the funds taken. If the exploitation involves consumer fraud, the Consumer Protection Act may be used to seek damages, but the client must, once again, agree to file the complaint with the court.

A competent, consenting client may agree to utilize the legal remedies described above and the worker should assist the client in contacting a District Attorney, legal services office, or private attorney.

A competent, consenting client may not wish to take legal action of the type described above, but may wish to simply prevent further losses. In that case, the worker should consider the following.

Financial Remedies Not Requiring Legal Action

If the exploitation act involved the exploited forcing the victim to sign over benefit checks, it may be possible to prevent a recurrence by having future checks sent directly to the bank for deposit or by having checks sent to a representative payee who will cash them and manage the funds. SSI, Social Security, and Veterans benefits may be handled this way.

While these measures will not ensure that cash held by the client is not taken by the exploiting person, these steps make it more difficult for the exploiter to obtain such funds and put the exploiter on notice that s/he is being observed. The worker should discuss with the client whether this type of action is likely to prompt the exploiter to retaliate in a violent or other manner. Strategies for protection should be discussed with the client.

If the exploiter is forcing the client to turn over cash from checks or bank accounts, then a variation might be tried. Funds could be deposited in a "co-signatory account" which requires two signatures in order to withdraw funds. This will place another roadblock in the path of the exploiter.

A conservatorship can be created even in cases in which the client is competent. This applies particularly to cases in which the client is physically incapacitated. Under this procedure, the person appointed conservator has responsibility for handling the ward's financial affairs in the best interests of the ward. Since this takes away a substantial portion of the client's liberty, it should only be used when other, less restrictive remedies fail and with the clear consent of the client.

If a conservatorship is sought, serious consideration should be given to petitioning the court for a temporary conservatorship for only such time as appears necessary to protect the client from the specific problem presented by the case and/or for a limited conservatorship which only allows control over specific financial affairs.

A useful course of action may be for the worker to discuss the situation, either directly or indirectly, with the exploiter in an attempt to convince him/her to cease. If the client agrees, the worker may request an attorney to attend the meeting as well, to further emphasize the serious nature of the matter.

When Abuse and Exploitation Are Both Involved

If the client is being abused and financially exploited, as is often the case, the remedies discussed above are appropriate. In addition, with a consenting client, a restraining order may provide a vehicle for obtaining relief. An order may be sought requiring the abuser/exploiter to vacate the home, to stop the abuse, and to stop cashing checks or taking funds from a joint bank account.

When the Conservator Is the Exploiter

If the exploiting person is a legally appointed conservator for the client, the above remedies may be appropriate. In most states, the worker may petition the probate court on behalf of the ward, assuming the ward consents, to remove the conservator. Legal counsel will be necessary to take this action, and the abuse or exploitation will have to be carefully documented.

HOUSING AND SUPPORT ISSUES

Housing and support services need to be coordinated for the client in most cases of abuse, neglect and abandonment and in some cases of exploitation. If the abuse, neglect or abandonment appears to be related to family stress which is at least partly attributable to the physical and emotional burdens of caring for the elder, then alternative shelter and/or support services may provide a means for relieving some of that stress. If the only effective preventive measure appears to be arranging for a separation of the parties, then alternative housing and support service planning is required.

When Only Support Services are Needed

If the client and the abuser live in the same household or if they live apart but the client is dependent upon the abuser for assistance with tasks of daily living, and there appears little to be gained by physically separating the two parties, then the worker and the client should determine what supportive services the client needs which might lessen the chances of further abuse or neglect. In order to do this, the worker should determine what support the client currently needs and what support the client currently receives from the abuser and from other persons or agencies. To make these determinations, the worker should attempt to talk with the abuser and with the service providers, if the client agrees to such further discussions.

The communication with the abuser may be a major step toward preventing further abuse or neglect. It may indicate to the abuser that s/he is not alone and that assistance is available.

Following these discussions, the worker should evaluate the supportive services which are available in the client's geographic area and are needed by the client. After discussing this with the client and reaching agreement on which services should be arranged, the worker and/or client should seek to obtain those services. To the greatest extent possible, the worker should have the client arrange for these services him/herself. Substituting dependence on the worker for dependence on the abuser is *not* a healthy turnabout.

Supportive services which the client may need include:

Homemaker or home health aid
Chore service
Visiting nurse services
Transportation
Meals in the home or in a group setting
Assistance with shopping
Mental health counseling or therapy
Recreational or group activities, and
Church activities

In addition, the worker should attempt to communicate with the abuser, especially if the victim and abuser are in the same household, about a services provision plan for the abuser. If it appears that counseling, therapy, alcoholism or drug treatment, or other such services are needed for the abuser, the worker should attempt to work with the abuser to arrange for such services.

When Alternative Housing is Needed

An alternative living situation may be required for the client in cases of abuse, neglect, abandonment and in some cases of exploitation. Physical moves for clients should be viewed as the least desirable alternative since such moves usually require the client to sever long-standing personal relationships as well as emotional ties with home and possessions. Some research suggests that such moves increase risks of mortality.

Short-term alternative housing may be necessary if the victim obtains a restraining order and/or vacate order against the abuser. Temporary removal of the client will ensure that s/he does not have to be in the home when the order is served on the abuser and will provide some short-term client protection against possible retaliation. Temporary housing might be found in the home of a relative or friend of the client, in a motel or hotel, or in a temporary shelter for men or women who are victims of spouse abuse.

While public housing authorities do not currently treat elder victimization cases as "emergencies" which allow for immediate entry of the client into public housing, workers should consider discussing this possibility with their local housing authority and should do so before an actual case arises. Public housing might become an available resource.

If it appears that the client and the abuser need to be separated because of abuse, as opposed to neglect, the worker should encourage the client to file a petition to require the abuser to vacate the current home. This will require the abuser and not the elderly victim to make the physical move. This can normally be done if the victim owns the home or pays the rent on the housing, but is less likely if the abuser owns the home or pays the rent.

If there is no alternative available which will allow the client to remain in the home, the worker should assist the client in finding permanent alternative housing. If the current living situation is dangerous to the client, it may require the worker to seek short-term and long-term housing options at the same time.

The difficulty of finding alternative housing and the poor health of many victimized elders frequently lead workers to the conclusion that hospitals or nursing homes are the best placements for their clients. Before recommending such a placement to the client, the worker should be certain that this move is in the best interests of the client.

Before any alternative housing move is made, the worker and client should complete the financial and supportive service planning assessment discussed above to assure that the client has his/her financial well-being protected and that the necessary support services will be available as soon as the move is made. Even when the client is the person who moves, it may be wise to obtain a restraining order against an abuser if retaliation or continued abuse appear likely.

Since some clients may be on medication or under regular medical care, the worker and client should be certain that any physical move does ont interfere with such treatment. The client's nurse or physician should be consulated about the possible effects of such a move and appropriate protective measures taken.

All of the measures described above need to be accompanied by a close and caring relationship between the worker and client. Weeks or months may pass before a successful resolution is achieved.

CASE PROTOCOL NO. 2

Type of Client: Competent, non-consenting client.

Characteristics of Client:

The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment (these four hereafter referred to as victimization).

The person is legally competent and has not been adjudged incompetent by a court of law and therefore has not had a full guardian appointed to oversee his/her life or assets. Nor has the client been committed to an institution by a court of law.

The person understands what has happened to him/her and does not at present desire to take action to halt further victimization, and may not be prepared to admit that victimization has occurred.

OUTLINE OF CASE PLAN

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected abuse, neglect, exploitation, or abandonment. This report will in all likelihood be from a third party and not from the client/victim. At this point, the worker may or may not have an indication that the client does not desire to take action to halt further victimization.

Initial Case Assessment: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information, and discuss methods for resolving the problem.

If the worker suspects that the client is not prepared to admit victimization and/or to take action to halt further incidents, the worker should be conscious that this initial contact may either open a dialogue with the client or end it. If the worker does not know how receptive the client will be to this initial contact, then the worker should proceed on the assumption that the client, will, at minimum, be hesitant to take action.

The worker should try to establish rapport with the client while gathering information utilizing non-directive questions. The worker should not press the matter if the client appears hesitant to give information about the alleged victimization. The goals of the initial case assessment are:

To open a dialogue.

To gather information and attempt to verify whether victimization exists.

To learn whether the client desires assistance to prevent further victimization.

To determine if other supportive services are needed.

The client has the right to reject any unwanted intrusions into his or her life. This initial case assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that this is a positive interaction. If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that s/he wishes to proceed with the case before proceeding further him/herself.

It is the client's right to refuse any assistance of any kind, including further visits from the worker. The worker should accept the client's decision and terminate the relationship.

To be certain that the client definitely does not wish to have any further contact, the worker should ask the client whether s/he is sure that s/he does not want any of the services which are available. This should be done by describing each service individually.

The worker should record these events fully in the client file for future reference and for his/her own self-protection.

The relationship between the client and worker should continue if the client refuses to either admit that victimization has occurred or desires to take no action to prevent further incidents, but does desire either continued contact with the worker or other supportive services. With many competent, non-consenting victims, this contact may be the most to be achieved at the conclusion of the initial assessment.

The client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with other parties, the worker should request and receive permission to do so from the client (in writing, if possible).

CASE EVALUATION AND CASE PLAN DEVELOPMENT: GENERAL CONSIDERATIONS

The worker and his/her supervisor should begin the process of conducting a case evaluation and developing a case plan if the worker is reasonably certain that the client has in fact been victimized and the client has not terminated the worker/client relationship. The client will control this process.

The worker and his/her supervisor should determine whether the worker will continue to be the primary worker or whether it should be transferred to a protective service worker or someone else with more time to devote. If it is decided that the worker will change, the worker should discuss this with the client and clearly indicate that another person will be contacting the client in the near future on this matter. This transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should accompany the new worker on his/her first visit to the client and should thoroughly brief the new worker on the facts of the case.

The case evaluation will have to proceed slowly, possibly extending over weeks or months. It should be controlled by the client's willingness to allow it to proceed. Until the client agrees to allow the worker to discuss the case with other persons, the worker has a responsibility to protect the client's privacy by not contacting others (family, friends, other service workers, etc.) to learn more about the client.

With a competent, non-consenting client, the case plan should be:

> To carry out the client's wishes for further contact and services, to the extent that those desires are possible and appropriate.
>
> To build a trusting relationship with the client which will result in the client's calling upon the worker for assistance with the victimization or with other problems.

The worker should continue to piece together the true facts of the case and provide such support as the client needs and wants.

While the client may never admit that victimization is occurring, s/he may agree to accept assistance which will alleviate some of the causes of the problem.

To the extent that the client agrees to accept assistance for other problems, s/he will also be broadening the access the worker has to other workers who have had contact with the client. With the client's permission, the worker may discuss the case with these other workers.

When the worker has developed a fairly complete profile of the client and his/her problems, s/he may present the facts of the case to a local protective services committee, a physician, nurse, mental health worker, lawyer, or other protective services worker. The client's identity should be concealed, but sufficient facts should be presented to allow for a discussion of the case. In this way, the worker may elicit ideas on how best to proceed with the case without violating the client's right to privacy.

As soon as the worker has a fairly complete set of facts concerning the case, the worker should develop a case plan consisting of a number of alternative courses of action which focus on providing support services and/or protection of the client and his/her property. The case plan should have as its goal the prevention of further victimization even if the client never admits that it exists.

CASE EVALUATION AND CASE PLAN DEVELOPMENT: SPECIFIC CONSIDERATIONS

In conducting the case evaluation and developing case plans for a competent, non-consenting client, the procedures described in the protocol for the competent, consenting client may be followed (and therefore will not be repeated in this protocol), with the following differences:

Existence of Victimiztion

The instance(s) of victimization will have to be discovered and verified without the client admitting its existence in most cases. Therefore, the worker will frequently need to use indirect questioning to obtain this information. Frequently, the worker will need to intuit what the problem is, which means that the worker needs to be very careful not to jump to the wrong conclusions.

Competency of the Individual

If the client does not have a guardian or has not been legally committed to an institution and clearly can function in his/her daily life without threat to him/herself, then the client is almost certainly competent. Therefore, use of guardianship or commitment procedures need not be considered by the worker as possible remedies.

Use of an Abuse Prevention or Domestic Violence Act

In the case of a competent, non-consenting client/victim of abuse, the use of an Abuse Prevention or Domestic Violence Act (if the state has one) will not be possible as the victim is the only one who can file a petition with the court under such an Act. Until the client admits that the abuse is occurring and agrees to take action under the Act, this remedy will not be available. At a later date the worker may want to again raise the possibility of using the Act.

FINANCIAL, HOUSING, AND/OR SUPPORT SERVICES ISSUES

Basically, the same alternatives available to the worker who has a competent, consenting client are available for a competent, non-consenting client. The difference is that the client will probably not admit that the victimization is actually occurring, but may admit that certain specific actions "might help" him/her function more effectively—e.g., changing the representative payee for the Social Security check might help him/her have easier access to funds; having a homemaker or transportation to the doctor might help the family care for the client; or getting out to a Senior Center or to a meals site might be enjoyable.

The main goal of cases involving competent, non-consenting clients who appear to be victims of abuse, neglect, exploitation, or abandonment is to prevent further victimization by providing support which they will allow. If cessation of abuse or neglect can be achieved without the client admitting that there is such a problem, so be it. Certainly acknowledgement of the problem helps the worker, but such an acknowledgement is not crucial to successful resolution of the case.

Case Protocol No. 3

Type of Client: Emergency case client.

Characteristics of Client:

The person is the actual victim of abuse, neglect, exploitation or abandonment. (These four are hereafter generally referred to as victimization.)

The result(s) of the victimization place the person in immediate danger of irreparable harm to self and/or property.

The person may or may not be legally competent, may or may not have been judged incompetent by a court of law, and therefore may or may not have had a full guardian appointed to oversee his/her life or assets. The client is not currently committed to an institution by a court of law.

The person may or may not understand what has happened to him/her and may or may not desire to take action to treat the results of the victimization.

OUTLINE OF CASE PLAN

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected abuse, neglect, exploitation or abandonment which places the person in immediate danger of irreparable harm to self and/or property. This encounter with the person may be the result of a chance meeting or a report from someone else.

Initial Case Assessment, Evaluation and Case Plan Development: Unlike other cases of elder victimization, emergency cases are unique in that the assessment, evaluation, case plan development and implementation must be done in a very short period of time—sometimes hours or maybe one or two days. As a result, the effectiveness of the assessment, evaluation and case planning take on heightened importance.

The client has the right to reject any unwanted intrusions into his or her life. This initial case assessment visit may be considered such an intrusion.

The right is inherent and may be infringed upon only if the person has been judged incompetent by a court of law or if the public health and safety demands or allows this infringement. The worker should use all of his or her persuasive powers to get the client/victim to agree to act in such a way as to protect him/herself from further harm.

Typical emergency cases involve clients who are or appear to be in severe need of medical attention due to neglect or abuse. Sometimes the emergency is not a health emergency, but instead is a financial emergency in which the victim is being exploited by another party and is in imminent danger of losing all or a substantial part of his/her funds or property. In any of these cases, the client may be competent, incompetent or apparently so, unconscious or semiconscious.

Clients in a Medical or Financial Emergency

In cases in which the client is or appears to be in a medical or health emergency, the worker often encounters a client who has been severely physically abused or has been the victim of severe neglect either imposed by others or self-inflicted. In cases of financial emergency, the worker may encounter a client who is in the process of being severely exploited by some person or is mismanaging his/her finances.

The worker's first encounter with this type of client will normally be either through a referral from another worker or through a home visit to one of the worker's own clients. In these cases, access to the client is usually no great problem since the worker either already has a good relationship with the client or can gain access by being accompanied by the worker or person making the referral.

If, however, the worker gets a report from someone who will not accompany the worker or does not know the client personally, then access may be a problem.

If the client is unconscious, access is certainly a problem, but normally the police can be prevailed upon to let a worker into the person's home.

If the client is conscious, the worker must receive permission from the client to take any action. If this consent is not received, the worker may not proceed without additional police or court-granted authority.

The worker should be especially careful not to over-react to cases of suspected victimization. The mere fact that the person is living in sordid conditions does not mean that an emergency exists. The worker needs to assess whether the situation is actually life-threatening or will cause irreparable harm to the person. Most of the information the worker will receive will come directly from the client. If the client is in a severe health condition, the worker should ask the client the name of his/her physician or health facility for a quick consultation.

POSSIBLE LEGAL REMEDIES

Abuse Prevention or Domestic Violence Acts

If the victim is competent but non-consenting, the civil remedies will not be available to halt further abuse. If the client consents, statutes in some states allow the courts to act within hours to order the abuser to halt the abuse and possibly to vacate. The client must simply demonstrate that the abusive situation is immediate and dangerous to his/her safety. Orders issued in this emergency situation are normally valid until the end of the next regular court working day, at which time additional protective orders must be sought.

Some states require the police to use all reasonable means to prevent further abuse if there is reason to believe that a family or household member has been abused and if the abuse is imminent and seeking a court order would take too long. This may include:

> Staying on the scene as long as there is danger to the physical safety of the person.
>
> Assisting the person in obtaining medical treatment, including driving the person to the emergency room of the nearest hospital.
>
> Giving the client immediate notice of his/her rights.
>
> Arresting the abuser if there is probable cause to believe a felony has been committed, or if a misdeameanor has been committed in the officer's presence. Informing the abused person that s/he can file criminal complaints for threats, assault and battery, etc.

Once the abused person has obtained a protective order from the court, any violation of the order is a crime. Violation of the order makes the violator subject to immediate arrest if the police has probable cause to believe that the order has been violated.

Temporary Guardianship or Conservatorship

If the client appears to be incompetent and is in an emergency situation, such as acute illness, a petition for a temporary guardianship or conservatorship may be filed. An attorney is usually needed to file the petition. Depending upon the facts of the case, the court may reduce or eliminate notice requirements to the proposed ward and his/her nearest relatives. The case may be heard and decided within a matter of hours or days, depending upon the emergency.

Because this remedy is so great an invasion of the person's rights and because notice requirements may have been severely reduced, the court will require strong evidence of the person's incompetence and the emergency nature of the case.

If the temporary guardianship or conservatorship is granted, it is time-limited and usually renewable only once. The guardianship or conservatorship may be either broad or limited to only certain types of decisions and actions. Normally, the courts grant broad orders, unless specifically requested to grant limited orders.

Emergency Commitment

The most restrictive remedy for any case, emergency or not, is civil commitment. It should be resorted to only in extreme cases. Civil Commitment is the process by which a court orders a person to be involuntarily confined for treatment in a mental hospital.

Civil commitment may be ordered only if strict criteria are met such as:

> The person is mentally ill, i.e., has a substantial disorder of thought, mood, perception, orientation or memory which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life;
>
> The person is shown to be dangerous to a degree that failure to confine would create a likelihood of serious harm to self or others; and
>
> Commitment is the least restrictive alternative.

A person may be committed involuntarily for a short period (usually a matter of days) upon application to a mental hospital by certain persons, such as:

> A physician designated by the facility;
>
> A police officer acting in an emergency where no designated physician is available;
>
> A trial court judge, after notice and hearing.

Specifics of emergency civil commitment vary from state to state.

If application is made by a physician or police officer, the person may be held during this time period without judicial intervention. However, the person must be given an immediate psychiatric examination, if none was undertaken prior to admission, and must be advised of his/her right to be admitted voluntarily. Additionally, a determination must be made at admission that confinement is the least restrictive alternative.

What happens after the temporary confinement? The person must be released unless the superintendent of the facility, or other authorized person, petitions the court for an extended involuntary commitment prior to the expiration of the temporary period. The person may remain hospitalized on a voluntary basis. Once the petition is filed, the person can be detained until a court hearing and the case is decided. Thus, an individual hospitalized on an emergency basis may be confined beyond the initial temporary period, often for several weeks or more, by the filing of a petition.

After the petition is filed, the court must notify the person and legal guardian of the Court's receipt of the petition and of the date on which the hearing on the petition will be held. Unless the hearing is waived in writing, the Court must then notify the person, his/her lawyer and nearest relative or guardian of the time and place of the hearing.

As noted earlier, the person has the right to be represented by counsel and to have counsel appointed if she/he cannot afford to hire a lawyer. At the hearing, the lawyer may call witnesses on behalf of the patient, cross-examine the hospital's witnesses (including the psychiatrist), and demand production of medical records and other documents. The patient also has the right to an independent psychiatric examination. If the judge finds that criteria for commitment are met and that the facility offers the least restrictive alternative for treatment, continued confinement will be ordered.

FINANCIAL, HOUSING AND/OR SUPPORT SERVICE ISSUES

The same actions available to the worker who has a competent, consenting client are available in emergency cases. (See competent, consenting client protocol for detailed description of activities the worker should consider and/or undertake). However, the worker must conduct many of these activities under severe time constraints.

It is in emergency cases that the value of protocols, pre-planned community responses, local protective services committees and formal and informal interagency connections pay the greatest dividends.

Privacy and confidentiality have a way of being violated in cases of perceived emergencies. The worker should, if possible, obtain the client's consent to talk about the case with other persons as necessary to prevent further harm to the client. If the consent cannot be obtained because of the client's incapacity, the worker should discuss the case with others only to the extent absolutely necessary to meet the client's needs.

If the client refuses to allow the worker to discuss the case with others, the worker should proceed only if he/she is certain that the client would suffer irreparable harm due to the emergency nature of the situation.

In emergency cases, there is likely to be a need for extensive support services, financial aid, and housing assistance. The worker may have to devote many hours to these tasks in a short period of time.

The client in most situations has a right to refuse assistance. These refusals should be documents in the case record with the date, time, and worker's signature.

CASE PROTOCOL No. 4

Type of Client: Incompetent client.

Characteristics of Client:

The person is an alleged or actual victim of abuse, neglect, exploitation, or abandonment (generally referred to as victimization).

The person is legally incompetent, which means:

S/he has been judged incompetent by a court of law and/or has a full guardian appointed to oversee his/her life and/or assets;

Of the person has been committed to an institution by a court of law;

Or the person has a severely limited understanding of what has happened to him/her and may or may not admit to victimization or care to take action to halt further episodes.

OUTLINE OF CASE PLAN

Initial Case Contact: A worker in a community agency receives a report of or uncovers a case of suspected victimization. At this point, the worker may or may not have an indication that the client is incompetent.

Initial Case Management: The worker contacts the victim/client to discuss the problem, verify the reported victimization, gather further information, and discuss methods for resolving the problem.

If the worker knows that the victim/client has a guardian or conservator, that should not deter or prevent the worker from meeting with the client. The worker should be especially attentive to the client's ability to understand information which is provided and the ability to make basic decisions. The worker should remember that the client has only very limited authority to make his/her own decisions about tasks of daily living. The worker should use this visit to try to gather information about the client's problem, not necessarily to make decisions with the client about tasks to be undertaken in the future.

If the worker does not already know that the client is incompetent or might be judged so by a court of law, this possibility will probably become apparent to the worker as the interview progresses. The worker should attempt to discern whether the client has real problems understanding the basic facts and concepts, and whether the client can care for his/her basic needs or recognize and cope with potentially harmful situations.

The primary purpose of this visit should be to gather information about the client's perceived needs and his/her situation; secondly, to begin to evaluate the client's competency; and thirdly, to determine what further assistance is needed.

After the visit to the client, the worker should record in the case file his/her observations concerning the client's needs, living situation, ability to understand basic facts, make basic decisions, and provide for basic needs. This is important so comparisons can be made in the future concerning the client's abilities to function at different times. The case record over a period of time should show whether the client is more lucid and capable at one time than another.

The client has the right to reject any unwanted intrusions into his or her life. The initial assessment visit may be considered such an intrusion. The worker should use all of his/her skills to make the client feel that this is a positive interaction. If the client refuses to have anything to do with the worker and expresses a desire to be left alone, the worker must respect this right to privacy. The worker should receive a clear indication from the client that he/she wishes to proceed with the case before proceeding.

If the client clearly states that he does not need or want assistance including further visits from the worker, that is the client's right. The worker should terminate the relationship. If the worker believes the client is incompetent and without a guardian then s/he should discuss this with the agency supervisor to determine whether the agency on its own behalf, or through family or friends of the client, should pursue the appointment of a guardian or conservator for the client.

The worker should ask the client whether s/he is sure that s/he does not want any of the available services. This should be done by describing each service individually.

The worker should record these events precisely in the client file for future reference and for self-protection.

If the client refuses to either admit that victimization has occurred or desires to take no action to prevent further episodes, but does desire continued contact with the worker or other supportive services, the relationship between the client and worker should continue. Continuing contact may be the most that can be achieved at the conlusion of the initial case assessment.

If the worker knows that the client has a guardian or conservator and the client agrees to some further contact, the worker should ask the client for permission to talk with the guardian or conservator if that appears necessary. If the client says no, the worker should accept that. However, if the worker feels very strongly that such a contact is necessary, she might tell the client that s/he will only proceed with the case if allowed to talk with the guardian or conservator. If the client says no, the worker has the choice of withdrawing from the case.

The client has a right to privacy and confidentiality concerning anything discussed with the worker. Before proceeding with further investigations and interviews with others, the worker should request and receive permission to do so from the client (in writing, if possible).

CASE EVALUATION AND CASE PLAN DEVELOPMENT: GENERAL CONSIDERATIONS

If the worker is certain or reasonably certain that the client has been victimized and that client wants to continue the worker/client relationship, the worker and his/her supervisor should conduct a case evaluation and develop a case plan.

The worker and the supervisor should determine whether the worker will continue to be the primary worker on the case or whether it should be transferred to a protective service worker or to someone else with more time. If it is decided that the worker will not be the primary worker on this case, then the worker should discuss this with the client and clearly indicate that another person will be contacting the client in the near future. The transfer of worker responsibility is critical and should be handled with great sensitivity to the client's needs. The initial worker should brief the new worker on the facts of the case and accompany him/her on the first visit.

In cases involving incompetent or apparently incompetent clients, there are three client types:

A client who indicates that his/her guardian or conservator is the victimizer.

A client who believes that his/her guardian or conservator is the victimizer.

A client who appears to be incompetent but has not yet been legally judged incompetent.

The three types of cases will need different treatment. In the first two cases, the client already has a guardian or conservator. The primary role of the worker will be to work closely with the client to attempt to determine if the guardian or conservator is in fact victimizing the client or otherwise neglecting his/her duties. If so, the worker should attempt to have the surrogate removed by the court and have someone else appointed, if that is still necessary. If the alleged neglect of duties is not verified, the worker should attempt to make this clear to the client and ask permission to discuss the matter with the guardian or conservator.

In cases in which the client/victim apparently is incompetent but has no guardian or conservator, the primary role of the worker will be to work with the client to attempt to create a situation in which the problem is alleviated, and the client receives the least restrictive protective care required. This may require that a petition be filed to appoint a guardian or conservator for the client.

In cases involving incompetent or apparently incompetent clients, the worker should seek the advice of an attorney and a local protective services committee. These cases involve legal, medical, and mental health issues, and usually require interagency cooperation.

The central issue in cases involving an incompetent client without a guardian or conservator is the client's ability to give consent. The worker may reach a point where s/he must decide whether the client has the ability to consent. If the worker decides the client lacks this capacity, the worker must decide whether and how to proceed.

If the decision is to proceed, the worker should seek to have a guardian or conservator appointed. At this point, the worker no longer represents the client's interests, necessarily, and should therefore help the client obtain a lawyer to represent his/her interests at the court hearing.

The worker has a responsibility to protect the client's privacy. Once the worker moves for a guardianship, conservatorship, or civil commitment, there is still a responsibility to maintain the client's privacy and to reveal only the facts concerning the client as are necessary and legally permissible for the limited objective(s) being sought.

CASE EVALUATION AND CASE PLAN DEVELOPMENT: SPECIFIC CONSIDERATIONS

In conducting the case evaluation and developing case plans for an incompetent client, the procedures described in the protocol for the competent, consenting client may be followed to a great extent (and therefore will not be repeated in this protocol), with the following difference:

Existence of victimization

The incidence of victimization must be discovered and verified with the permission of a client who may lack mental competence and may have limited periods of coherence. The worker may be hesitant to accept the assertion of the client concerning the alleged victimization. In some cases this will make the verification process difficult.

The worker should seek the consent of the client to discuss the case with other persons who may have information regarding verification. The worker should use every means available to enable the client to understand what s/he is being asked to consent to and the consequences of giving this consent. Once the consent is or is not given, the worker should carefully describe in the case file what the client was told and the client's response.

Use of an Abuse Prevention or Domestic Violence Act and other remedies in cases of elder abuse

Usually only the victim of abuse can file a petition with a court under an Abuse Prevention or Domestic Violence Act. There remains a major issue of whether a court will consider the petition of a person who has already been judged incompetent or who quite clearly does not understand basic facts and the implications of his/her decisions. At this point the client should be represented by legal counsel.

If the client has a non-abusive guardian or conservator, then s/he should probably be the petitioner on behalf of the client. If the current guardian or conservator is the abuser, then a petition should be filed to remove the guardian or conservator. It may or may not be necessary to also file a petition under the Abuse Prevention or Domestic Violence Act. In the latter situation, there must be strong evidence to support the removal of the guardianship, and the court will probably require more than the client/ward's word.

The worker should discuss with his/her supervisor whether the agency should petition for the removal of the guardian or conservator if the current guardian or conservator is the abuser and the client/ward does not consent to the removal of the guardian or conservator, or simply does not comprehend the worker's explanation of what this means or will do. Generally, anyone may petition for the removal of the guardian or conservator. At the same time, a petition for a temporary restraining order against the abuser might be sought to protect the client.

When neglect or exploitation exists

If abuse has not occurred but either neglect or exploitation exist, and the client has a guardian or conservator or is in need of one, then the following actions might be taken.

If the client has a guardian or conservator and the worker verifies that s/he is the person responsible for the neglect or exploitation, then the worker should informally approach the person and suggest that s/he improve his or her performance. If that should fail, the worker should be prepared to have a petition filed for removal of the person as guardian or conservator, or to arrange for a lawsuit against the guardian or conservator for breach of duty.

If it appears that harm might be inflicted upon the client as a result of these petitions, they might be filed as emergency petitions along with a request for such restraining order or injunction as necessary to prevent harm.

The worker, client, and legal counsel should work together to petition for a guardian or conservator if the neglected or exploited client does not have a guardian or conservator but appears to meet the standards required for creating a guardianship or conservatorship and this would be the least restrictive alternative.

Seeking a guardianship or conservatorship infringes on the client's liberty. Before seeking either remedy, the worker should develop a number of case plans for resolving the client's problems. Various remedies which are less restrictive but may provide a means for alleviating the neglect or exploitation include the following:

Representative payee
Trusts
Direct bank deposits
Joint bank accounts
Powers of attorney

Each of these remedies has limitations and/or drawbacks and therefore each should be discussed with an attorney before recommendation to the client. If the client is clearly incompetent, these remedies will not be appropriate.

FINANCIAL, HOUSING AND/OR SUPPORT SERVICES ISSUES

The same actions that are available to the worker for a competent, consenting client are available for an incompetent client. The difference is that if the client is incompetent, the case planning will need to be done in conjunction with the guardian or conservator. If the guardian or conservator is the source of the problem(s), then the worker may have to ask him/her to improve performance or seek his/her replacement. The worker will then need to develop and implement the case plan in conjunction with the new guardian or conservator.

A responsible guardian or conservator may be all that is needed to protect the client from further victimization. But it may also be necessary to locate alternative housing or provide other support services. In these cases, the goal is to assure that the client has a responsible surrogate and that, through that surrogate's help, the client receives necessary services.

PART III: DEVELOPING STATE AND COMMUNITY RESPONSE SYSTEMS

CHAPTER 7—PROTECTIVE SERVICES SYSTEMS

Elderly abuse is rooted in a diversity of factors, including the expectations of family members in caring for elderly parents, family relationships, and the external and internal stresses on the family. There is no simple answer as to why abuse occurs. There is, likewise, no simple solution. The complexity of the problem demands a comprehensive approach to its solution.

It is necessary to organize the full range of identification, assessment, treatment, and prevention service available to victims and their provision, sometimes with disastrous results. Emergency cases in particular require a prompt and comprehensive response.

Current research indicates that well-organized protective service systems generally do not exist to cope with the problem of elder abuse. In most communities, a wide variety of health, social, and legal services are available to assist elders who are in need, but they have not been molded into a single, cohesive delivery system for abuse victims.

This chapter discusses what is needed to create such a protective service system in a community or state.

The model consists of:

General systems characteristics which any community should keep in mind when setting up an adult protective services system serving abused and neglected elders.

A listing of core services which are essential to any such protective services system.

A listing of additional (and important) support services which are largely unavailable in most communities.

A delineation of those tasks which could be most efficiently undertaken on a statewide—as opposed to community—level.

GENERAL SYSTEMS CHARACTERISTICS

Any effective protective services system must have two essential ingredients:

Pre-planned individual case responses or protocols which enable the system (and its individual workers) to respond quickly and properly to the type of case being confronted.

The capacity for a coordinated, interdisciplinary response on the part of the service system to both emergency and chronic situations.

Interdisciplinary Response

Abuse is a multi-dimensional problem that requires assistance from many service agencies. Services which are available in a given community must be coordinated for individual cases. An efficient means of developing this coordinated response is the formation of a formal protective services committee composed of representatives of agencies who agree to provide services to abused elders.

The inter-agency committee's role is two-fold:

To establish linkages between agencies that will lead to protocol development and the timely coordinated delivery of services.

To provide an on-going review mechanism for individual cases.

CORE SERVICES IN A PROTECTIVE SERVICES SYSTEM

While the services required by individual clients will differ, a protective services network for abused elders should be able to provide a basic group of core services, many of which are currently available in most communities.

These core services can be provided through one umbrella agency or through formal agreements between providers. The formal agreements can be contracts to purchase services, but need not involve a transfer of dollars. Instead of exchanging dollars for services, a quid pro quo arrangement can be made through which units of one service are matched or exchanged for units of another service.

The Protective Services Worker

Because of the many disciplines and services which must be brought together in an abuse case, it is essential that one person be held accountable for managing a given case. This person, the protective services worker, plays a crucial role in linking community resources to the victim *and* his/her family and in assuring the system's response to change in the victim's environment. The protective services worker should also be the means for linking the victim's family and, if possible, the abuser to supportive and counseling services.

A protective services worker may be a worker who handles only abuse, neglect, exploitation, or abandonment cases or a worker who handles a range of cases. Opinions differ as to which approach is best. Often, available funding is the determining factor. Whichever the approach, to be effective the protective services worker must have:

A flexible case load.

Authorization and ability, at any time, to devote 5 to 40 hours a week to one case if necessary.

Authorization and ability to assist workers in other community agencies on their cases so that informal, mutually supportive arrangements can be developed.

A supportive and knowledgeable supervisor.

Adequate training prior to handling abuse cases.

A knowledge of virtually all financial, housing, health, mental health, legal, religious, and social services in the community.

Designating specific persons as protective services workers for abuse victims is an important means of assuring the system's accountability to the client. Recent literature also shows the importance of a stable and on-going client-worker relationship in successfully dealing with abusive situations.

A Case Assessment Team

Once a suspected case of abuse is reported, the system must be able to valuate the need for services and provide the most appropriate response. In the most complete system, this assessment would be made by a team composed of:

A physician with geriatric experience (or a nurse clinician under the direct supervision of a doctor).

A trained human services professional with gerontological and casework experience.

A lawyer.

A psychiatric case worker.

Not every case of suspected abuse will require a complete evaluation by every member of the team. In some communities, resources might not be available to have such a team meet regularly. In such instances, a trained worker could perform an initial assessment, using certain pre-determined protocols for calling in other experts to assure access to a full range of assessment skills.

The assessment team or assessment worker will need to work closely with legal counsel. The role of the counsel at this point is to assist the assessment team or worker with a legal evaluation of the case and to provide legal advice as to the proper steps to be taken by the team or worker in the case.

Primary Health Care Services

These services may be delivered at home or on an inpatient or outpatient basis. They include:

Nursing care.
Physician services.
Hospitalization.
Mental health services.
Emergency Room services.
Ambulance service.

Legal Services

Legal services needed in elder abuse cases are of two distinct types: services for clients and services for workers. In cases of mentally competent clients in which the client and worker agree on the case plan, the same lawyer may serve both the client and the worker. However, when the client and worker disagree on the case plan or when the client is mentally incompetent and the worker wants to petition for a guardian, conservator, or civil commitment, separate legal counsel should be available to the client and the worker.

Legal services for the client may include:

Advice and possible representation in criminal or civil actions against the abuser.

Advice on potential eviction, utility shut-off, SSI or Medicaid termination, health care or social service denial, and similar matters.

Advice and possible representation in a guardianship, conservatorship, or civil commitment proceeding.

Advice and possible representation in a right to treatment or a right to refuse treatment situation.

In cases where guardianship or other means which would restrict the client's rights are being contemplated by the protective services worker, legal counsel for the client should be arranged as soon as such action is considered. At that point, the system and the individual are in an adversary position, and the client should have legal counsel to protect his/her rights.

Legal services for the client may be obtained from local legal services offices, legal programs for the elderly funded by Area Agencies on Aging under the Older Americans Act, bar association referral programs, and private attorneys.

Legal counsel for workers is frequently non-existent. Agencies often view it as an expensive frill. Yet it is essential in many elder abuse cases. Specifically, workers may need advice on matters such as:

Worker liability for possible slander, alientation of affection, invasion of privacy, or trespass.

Right to information under the Freedom of Information laws.

Issues involving responsibilities to act or not act in certain circumstances—e.g., to report or not to report a crime committed by the client's family against the client.

Standards for imposing a guardianship or conservatorship.

Finally, in some cases, the worker and agency may need legal representation to petition for a guardianship, conservatorship, or civil commitment.

Providing legal counsel for both clients and workers is essential in protective services cases. It helps assure that workers can best serve their clients and that clients' rights are protected.

Legal counsel should also be utilized for staff and community training and education sessions on protective services issues.

Homemaker/Home Health Aide Services

Public and private homemaker/home health aide agencies in most communities provide housekeeping services, meals preparation, shopping assistance, and other similar services.

Transportation

These services may be available through social and health service agencies, Area Agencies on Aging, religious groups, private charitable organizations, and public and private transportation systems. Friends and neighbors may also be helpful in providing this service.

Nutrition

These services include meals-on-wheels, congregate meals, shopping, and cooking services, and are available through local Older Americans Act nutrition programs, church groups, and other private charitable organizations.

Financial Assistance

In some case of elder abuse, the victim may be dependent upon the abuser for support. It is important therefore for the protective services system to have either some cash on hand or other means for assisting the client through an immediate financial crisis. The protective services system must also be able to handle long-term financial needs. This means the protective services workers must have a working knowledge of all income and other public benefits programs.

Police Services

Police should be contacted when the client is in *imminent* danger of bodily harm in order to assure the worker access to the premises and, if necessary, to assist in removing the client from harm. Police can also arrange ambulance services.

Under some state Domestic Violence statutes, police play an important role in protecting the victim from continuing harm, enforcing restraining or vacate orders, and arranging services for the victim.

A role for which police presence is *not* appropriate is to assure access where imminent danger to the client is not a factor. Inappropriate use of the police by the protective services worker may create hostilities in the victim and family which will be difficult to overcome.

Emergency Services

The protective services system must be able to provide immediate services to diminish or prevent the threat of grievous bodily harm or death to a client. This emergency capacity should include a 24-hours-a-day, seven-days-a-week response capacity and the following services:

Emergency housing (at least two nights duration).
Emergency medical care (in the home or by ambulance to service site).
Emergency funds.
Legal services (for advice to or representation of the client).

Emergency services should not be limited to crisis intervention. Clients receiving emergency services should be mainstreamed into the client pool as soon as the emergency has been resolved. Reliance on crisis intervention alone results at times in inappropriate case diagnosis or repetitive abuse.

Follow-up

All cases, regardless of disposition, should be reviewed on a regular basis. An initial review might be conducted by the protective services committee within thirty days of the opening of a case and each ninety days thereafter.

SUPPLEMENTS TO CORE SERVICES

More of the core services listed above, while not evenly distributed or adequately funded in all or even many geographic areas, do exist throughout most states. The major gaps in core services are normally the lack of protective services workers, case management teams, and legal counsel for workers. The main need is to organize the services into protective services systems and to assure their availability to victims of abuse.

Other important services listed below are often unavailable, however, and unavailability seriously weakens the system's capability to deal with cases of elder abuse. While individual communities may be able to establish these services for their client, a national or state-wide effort is needed to assure their availability in all areas.

Emergency Shelter/Housing

This need constitutes perhaps the single greatest gap in services to victims of elder abuse. Workers are frequently forced to rely on hospital and nursing home beds for placement of abuse victims. Experience indicates that the lack of emergency housing often results in temporary hospitalization followed by inappropriate placement in a nursing home.

In some instances, removal of the victim from the abusive situation is the only way in which s/he can be protected. While hospitals and nursing homes may be suitable placements for certain individuals, alternative, short-term options are needed for many others.

State or federally funded projects are required in this service area. Until such programs are established, existing community facilities should be coordinated to help provide emergency housing. Convents, dormitories on college campuses, guest houses, and public housing should be considered. Often special facilities and services must be added to accommodate the needs of frail or handicapped elders.

Counseling Groups for Victims and Abusers

As indicated, one of the most difficult problems in dealing with cases of elder abuse is the unwillingness of the victim to talk about it. For various reasons, many battered elders refuse to confront the fact of their victimization. Individualized counseling for abuse victims is often needed throughout the investigation, assessment, and service delivery phases of the case.

Group counseling may also be an effective means for helping the elder cope with victimization. Models for this type of service are provided by existing self-help groups such as organizations serving rape victims.

Thought should be given to the formation of self-help groups for abusers. Parents Anonymous, an organization of parents who have abused their children, provides a successful model in this area.

Foster Care for Elders

Foster care for elders is a new service concept being piloted in a small number of areas in the country. This and other long-range placement options (such as congregate housing) are necessary for victims of abuse who can no longer live alone or who must be removed from their family's care.

Day Care or Recreation/Activity Centers for Elders

Respite care for elders (both on a regular daytime basis and for weekends or longer periods of time) gives families a break from their sometimes overwhelming responsibilities. Respite care may serve both as a safety valve in preventing abuse *and* as a helf-way step, once abuse has occurred, which permits families to readjust gradually to caring for the elder.

In instances where the abused elder has led an isolated existence, day care and recreation programs can help provide a necessary social and support structure.

Statewide or Uniform Service System Characteristics

The model protective services approach described in this chapter does not assume the passage of a statute mandating elder abuse reporting or the designation of a single state agency responsible for handling abuse cases. While these are important, and should be actively encouraged, it is possible for communities to begin framing their own responses to elder abuse within existing legal and administrative structures.

Standard Record Keeping

The protective services system can be improved by standardized record keeping which permits audits for service and client characteristics. Records should reflect service goals as well as case-work process and should be kept by client number so that confidentiality can be maintained during case reviews.

Uniform record keeping creates both data for planning purposes and a case review capacity which promotes timely handling of cases, systematic reviews of individual client progress, and adequate fair hearing and grievance procedures for clients and their families. An annual report based upon this information should be prepared by a designated state agency.

Uniform Eligibility Guidelines

Adult protective services are usually funded under Title XX of the Social Security Act. They must be provided without regard to income. The question of whether to include disabled persons over eighteen years of age in any statute which mandates adult protective services, or to confine legislation to the sixty-plus population is obviously an important one, since this decision will have an impact on the design of the services delivery system and the cost of the program.

Uniform System of Case-Finding, Reporting, and Referral

While it is not essential that a single agency be designated in each area for receiving reports of elder abuse, or that the agency be identical across all areas of the state, it is important that this responsibility be clearly pinpointed in each service area. A network of agencies, such as visiting nurse associations or hospitals, could be designated to perform this function and be responsible for subsequent referral to other community organizations. Social service or family service agencies could also be designated.

Regardless or which agency/agencies are designated in each area or community, it should:

Receive abuse reports.

Assign an assessment worker or a team to investigate each report.

Refer the case to a protective services team or worker for case planning and services delivery.

This agency should receive regular status reports on all referred cases.

Confidentially Guidelines

A great deal of uncertainty and confusion exists around issues of confidentiality as they relate to elder abuse cases. Because of the need for coordinated service responses, it is necessary to share client information across a number of agencies when dealing with cases of elder abuse. In instances where abuse is merely suspected, assessment of the problem may often involve client release forms and procedures for protecting client information would be useful. Such uniformity would help assure that the client's right to confidential treatment is respected equally in all agencies and areas of the state.

Training

Protective services workers, counselors, assessment team members, information and referral workers, and emergency telephone personnel—indeed, most persons who participate in a protective services system for abused elders—need training. Traditional skills in case management, record keeping, community organization, and case work are also essential in the successful handling of cases. For training suggestions in the field of elder abuse, see Chapter 10 of this Manual.

Funding

Although communities can begin the systems development work outlined above, certain vital services (such as emergency shelters) do not currently exist and require state or federal funding. Specialized skills and positions (such as the protective services worker) may not be available in many communities, and existing service providers may be unable to guarantee slots or units of service for abuse victims because of existing case loads or waiting lists. Priority setting at the state level (both programmatic and fiscal) is crucial if a uniform and serious effort is to be made to address the problem of elder abuse. Federal funds should also be specifically directed to this problem area.

CHAPTER 8—MODEL ABUSE REPORTING AND HANDLING LEGISLATION

In the past quarter of a century, family violence in America has become a major but unsolved societal problem. The "solutions" to the problem of child and spousal abuse have, more often than not, failed. Society must look at and learn from its past mistakes in dealing with child and spousal abuse in order to institute an effective, workable response to the problems of elder abuse.

SPECIAL CHARACTERISTICS OF THE ELDER ABUSE PROBLEM

While similar to child and spouse abuse cases, elder abuse cases present certain unique characteristics which indicate that the child or spouse abuse response systems cannot be applied unchanged to create elder abuse response systems.

Among the characteristics which make elder abuse cases different from spouse abuse cases are the following:

The elderly victim is much more likely than the spouse abuse victim to be physically frail and therefore dependent upon the abuser for physical care.

The elderly victim may be mentally incompetent or deteriorating mentally for medical reasons associated with advanced age.

The abuser of the elderly person is likely to be a blood relative and the elderly person often feels some responsibility for his/her character and therefore some personal guilt for any character defect.

In addition to the differences between child, spouse, and elder abuse, there are of course many parallels, the basic parallel being that virtually all of the cases involve violence within the family. This single common factor should be central to any planning that is done to create a response system.

A second, also obvious, yet critical, factor, is that all these cases involve two persons who need help—the victim and the abuser. Rarely will future abuse be prevented unless the needs of both parties are adequately addressed. Even legally enforced separation of the parties may be only a partial solution.

Some states have begun to address the issue of elder abuse by enacting mandatory adult or elder abuse reporting and handling laws. Other states have responded to adult abuse by enacting new civil and criminal remedies for persons abused by family or household members.

Chapter 5 provides a brief analysis of the criminal and civil remedies available in abuse cases, while this chapter contains analysis of the provisions which should be included in a mandatory abuse reporting and handling statute.

Most experts agree that mandatory reporting legislation unsupported by available and mandatory social and health services can result in serious harm to the elder person which can include displacement from the home, premature and unnecessary institutionalization, and wholesale "dumping" of our elders onto an inadequate state system. The key to effective mandatory reporting laws then is the availability of an array of supportive services.

In addition, legislation, drafted to include a means for providing social and health services to the abused, must set forth the framework for procedures which can establish surrogate authority in cases where the abused elderly person lacks the capacity to consent to services or manage his/her own life and property. Concurrent with these procedures there must be protection of the due process rights of the elderly individual.

CURRENT ABUSE REPORTING AND HANDLING LAWS

By the end of 1980 approximately 15 states had adopted some form of an abuse reporting and protective services law. [1] This type of legislation varies from state to state but generally it includes some or all of the following:

Access by social service workers to investigate abuse, neglect or exploitation;

The mandatory reporting by certain categories of people of abuse, neglect or exploitation with immunity and confidentiality assured and penalties provided for failure to report;

The voluntary and involuntary provision of protective services;

The safeguarding of individual rights against inappropriate intervention.

The issues raised by this body of legislation are controversial as well as complicated. Any discussion regarding the best and most effective legislation involves complex questions of a legal, medical, and psychological nature. Answers must preserve the intricate and delicate balance between the principle that society has the duty to protect those unable to protect or provide for themselves, and the constitutionally assured rights of personal choice and individual freedoms.

Key Issues

The critical provisions of an abuse reporting and protective services law are those which determine how the conflict between individual rights and state intervention is resolved; whether there are sufficient service provisions to meet the needs of persons under the purview of the law; and how to establish payment procedures for services rendered. In short, essential provisions which should be considered are:

The definition of persons covered by the law.

The standards for reporting and investigating as they affect the rights of privacy and confidentiality.

The right of access into private homes to investigate and to provide services.

Due process safeguards in the determination and provision of services to involuntary cilents.

The establishment of adequate services to meet the needs of those under purview of law.

Sufficient funding for services so that everyone in need can use them.

Persons Covered

The premise of protective services legislation is that persons exist in society who are unable to care for and/or protect themselves. Society, in the form of the state as parens patriae, assumes the responsibility of this care and protection. The criteria for state intervention should be one linked to the existence of abuse, neglect, exploitation, and/or abandonment and to a functional, mental, or physical inability to care for or protect oneself. The scope of the law and determination of need on the part of the person covered should be defined to assure that vulnerable persons who are abuse victims are protected and reached by services.

Of the state with legislation, a majority of the laws apply to persons "in need of protection services" or those "incapacitated" and abused, neglected, or exploited.[2] Whereas the latter is linked to a physical determination, the former criteria, unless clearly defined in the legislation, fails to define an actual standard. This could result in potential confusion in mandatory reporting and in the increase of inappropriate intervention.

Other legislation relies upon the medical model of developmentally disabled infirmities of age and senility in the determination of the coverage of the law.[3] This determination must be questioned. These standards, as applied to the elderly, mean the diagnosis of acute or chronic brain syndrome, a condition typically thought to be an organic brain dysfunction. Evidence indicates that such a catch-all diagnosis may in fact be a self-fulfilling prophecy which masks conditions such as vitamin deficiency, depression, dehydration, over-medication, or injuries. The failure to treat these conditions results in further deterioration until organic dysfunction may actually exist. The physician often relies on information about the elderly person's condition provided by a caretaker. The opportunity for bias is obvious. Criteria discussed in this paragraph fail to take into consideration that some infirm elderly are in need of protective services but are not senile or suffering from the "infirmities of age" (organic brain syndrome). By either diagnosing them as such or denying them services by applying the standard more strictly, the elderly person suffers.

A standard linked to functional ability to care for and/or protect him/herself and existence of abuse, neglect, exploitation, or abandonment [4] best defines the class in the manner most likely to include the largest number of persons in need, without increasing the likelihood of inappropriate intervention.

All but one state, namely Virginia, define need for services to be a question of behavioral or functional capacity. Virginia's standard refers to the individual in need who lacks sufficient understanding of capacity to make or communicate responsible decisions. This standard is clearly inadequate. Not only does it fail to address the central issue of the individual's ability to provide for his/her basic needs, but it bases the determination on the cognitive ability to make "responsible" decisions. This vague-laden standard opens the door for inappropriate intervention in cases where some surrogate authority decides that a particular decision is not "responsible," irrespective of the individual's ability to function and provide for his/her own needs.

Reporting and Investigation

Eleven states have explicit reporting provisions. Six of these states make reporting mandatory for anyone who has reasonable cause to suspect or believe that an individual is a victim of abuse, neglect, or exploitation. The remaining five states restrict reports to either practitioners of the healing arts solely or to a broad category of professionals including physicians, nurses, and social workers.

None of the legislation reviewed addresses the question of confidentiality as it applies to medical practitioners or the clergy. The assumption is that the law requires reporting even where confidentiality will be betrayed. This is in keeping with the notion of the importance of the societal interest in the preservation of life.

Several reporting provisions include a sanction of jail or fine for failure to report. The use and effect of such sanctions in adult protective services laws is still unknown. Similar sanctions contained in child abuse reporting laws have not served to increase the social responsibility for reporting the persons involved, nor have these provisions been seriously enforced.[5]

All of the reporting laws require that, following the filing of a report to the designated agency, the agency investigate, evaluate the circumstances, and make a determination of need promptly or within a specified period of time, such as 72 hours. The investigation must include a visit with the person believed to be abused and consultation with persons knowledgeable about the facts of the case. The ability of the agency to respond adequately to reports is a key issue which is linked to fiscal considerations. Some statutes include provisions limiting agency responsibility depending on availability of funding. This raises the question of whether these laws are backed by sufficient appropriations. A review of service provision systems in the states with protective services laws is necessary to shed light on the issue.

If an investigation indicates that the elderly person is or has been abused, neglected, or exploited and is incapacitated or in need of protective services, the agency will either develop a service plan or refer and contract out to another agency to develop such a plan. Voluntary services provision can begin if the individual consents.

Statutory reporting provisions must be coupled with procedures to assure the investigator or service provider access to the person believed to be abused. The agency can petition the court for injunctive relief to gain access upon proof of "reasonable cause to suspect" abuse, or to enjoin the caretaker from interfering in the provision of services. The burden of proof placed on the agency seeking injunctive relief is intended to prevent inappropriate intervention.

If services are refused or consent is withdrawn by the individual, the case must be closed except when the department/agency establishes that the individual lacks the capacity to consent. This standard is vague and the determination of capacity is rightfully left to the courts where the individual has some assurance that limitations on his/her rights will not be imposed without due process of law.

PROVISIONS FOR SERVICES TO INVOLUNTARY CLIENTS

At times an agency will find an elderly person who is in need of immediate assistance. If consent is secured, no legal action is needed. If consent is refused, the department must make an initial determination of the individual's mental capacity to consent as well as decide whether an emergency exists. If there is no doubt about the client's lack of capacity to consent, involuntary services may be provided only with court authorization secured pursuant to the state's guardianship statute or protective services provisions.

The area of emergency intervention raises the conflict between state interests and individual rights and many states lack well-defined procedures to regulate emergency intervention. Some states, such as Kentucky and Connecticut, do not provide for emergency intervention within the adult protective services statute. In these states, reliance is on voluntary service provision and injunctive relief if access is denied. Involuntary services may only be provided pursuant to established guardianship and commitment procedures even when limited intervention would suffice. This approach is contrary to the doctrine of the least restrictive alternative.

Even more unsettling are provisions of statutes in states such as Alabama and Florida. In Alabama, notice of a hearing on the merits of protective placement must be given within 10 days and, if read in conjunction with the provisions on protective placement, a hearing must be held within 30 days of filing of the petition. The Alabama statute pertaining to emergency placement states:

> If the person is incapable of giving consent or *does not consent*, the department shall petition the court for an order authorizing the department to arrange for care for such person immediately. Upon a determination by the court that such care is urgently and immediately necessary . . ., an appropriate order . . . shall be issued . . . to arrange for the placement of such person in an approved foster home, licensed nursing home, or other similar facility immediately.[6] (Emphasis added.)

The due process violations of Alabama's statute are glaring. The statute as adopted does not include an emergency services provision, but focuses solely on involuntary protective placement for persons unable or unwilling to consent. There is no question of competency here. Thus, the individual who is competent and refuses services may still be the subject of involuntary protective placement. The statute inadequately provides for representation, the right to be present at a hearing, and notice of the hearing. In other words, in Alabama, anyone who is deemed to be urgently in need of care, whether competent or not, may be placed in a nursing home or other facility, excluding a mental institution, for anywhere from 10 to 30 days without an opportunity to be heard and with no assurance that any hearing held will adhere to the notion of due process. [7]

According to Florida's Adult Protective Services Act, [8] involuntary removal and placement can take place when authorized by court order. Although a preliminary hearing must be held within forty-five hours to establish probable cause for protective placement, custody can be continued for four days pending a hearing on the need for continuing services. These provisions do not include the right of representation, the individual's right to be present, or notice requirements. The statute also fails to provide for a determination of the individual's lack of capacity to consent, a prerequisite to involuntary placement. The only criteria spelled out in the statute is that an individual suffering from the infirmities of age who is being abused, maltreated, or neglected may be subject to this procedure. These standards are insufficient when held up against the constitutional guarantees of due process.

In addition, both the Alabama and Florida statutes fail to articulate the standard to be met in the course of a protective placement hearing. The potential for serious deprivation of personal liberty should require that the petitioner prove the facts alleged by clear and convincing evidence. A mere "preponderance standard" is inadequate when involuntary institutionalization is a likely result. Yet neither statute provides for this.

Other states, such as Tennessee, Virginia, North Carolina, Oklahoma, and Maryland, have adopted statutes which provide, in varying degree: due process standards, notice, limited intervention prior to a full hearing, and simplified petition upon sufficient facts of an emergency and inability to consent. Such provisions are more consistent with the notions of constitutionally protected rights of privacy and due process.

Yet this is insufficient. Despite such safeguards, there exists an inherent weakness and potential for abuse in statutes that rely on vague, undefined terms such as "lacks the capacity to consent." Medical and legal labels of incompetency and capacity are unusable because, in many cases, they include personal judgments on the part of the evaluator. Appropriate intervention can only be determined if functional disability can be identified and defined. By failing to address this issue, the statutes leave the door open to inappropriate intervention. [9]

Least restrictive alternative

Most states' protective services laws require that services provided should be the least restrictive of the alternatives available. This indicates an acknowledgement by the state of its obligation to provide care and protection with the least necessary restrictions on the person's liberty and civil rights. [10]

Although infringement of basic rights has been accepted by the courts when there is a "compelling state interests," the degree of infringement ought to be

118

related to the degree of legitimate state interest in the protection of the individual, pursuant to parens patriae and the protection of society, pursuant to the police power. If this principle is accepted, the specific services provided and the manner in which they are provided, such as protective placement, should be appropriate to the individual case and allow for the freatest possible exercise of the person's liberties. Acceptance of this principle, unfortunately, does not guarantee that a genuine search for less restrictive alternatives will, in fact, occur; nor does it guarantee the availability of these services.

There are two major considerations that come into play in determining the most appropriate and least restrictive services:

> *The determination of the need for services and their availability.* Only one state makes use of a geriatric evaluation team at the point of involuntary placement to assure a suitable case plan and placement.
>
> *The development and funding of community-based alternatives*, such as congregate housing, foster homes, and extensive in-home services. If these alternatives are not pursued as options or are inadequately funded, the only placement available will be a nursing home facility or a hospital. Lack of such less restrictive alternatives makes the inclusion of least restrictive alternative requirements in any legislation almost worthless.[11]

In summary, existing statutes and remedies are, by and large, inadequate. Although predicated on the importance of utilizing the least restrictive alternative in treatment and placement, there is insufficient funding and development of such programs and alternatives to make this promise a reality. Legal remedies and intervention procedures do not always include service provisions that provide protection of the physical welfare or of the constitutional rights of the individual. There is too often reliance on inappropriate intervention procedures in violation of constitutional standards, because of the system's desire to do what is "best" for the client.

Even the best of laws cannot obscure the need to develop extensive social service networks to resolve the underlying problems which give rise to elder abuse cases. Nor can the issues be addressed without giving attention to the rights of the elderly in our society to choose for themselves how to live and, perhaps, how to die.

RECOMMENDATIONS FOR PROVISIONS IN ABUSE REPORTING AND HANDLING LEGISLATION

The following are recommendations for an abuse reporting law that mandates adult protective services. While accepting the basic principle that society has an obligation and duty to provide protection and care for particular persons, the recommendations reflect concern for the rights of the individual to self-determination and to due process of law. It must again be noted that any mandatory reporting law without appropriate supportive services may do more harm than good in that it could result in inappropriate action being taken such as unnecessary institutionalization.

The law should apply to persons 60 or older who are abused, neglected, exploited, or abandoned, and possibly to persons 18 and older who lack the physical or mental capacity to care for their basic needs and/or protect themselves.

All important terms, such as abuse, neglect, exploitation, and abandonment, should be clearly defined in the statute.

One state agency should be responsible for developing an adult protective services program for all citizens, and for providing these services either directly or through contractual arrangements.

Within a short, prescribed period of time after noticing signs of abuse, a report should be required from certain categories of persons, including physicians, nurses, social workers, coroners, medical examiners, dentists, hospital staff, nursing home staff, homemaker and home health agency staff, clergy, adult foster care facility staff, and police officers. Anyone else who has "reasonable cause to believe or suspect" abuse may report this information to the designated agency.

The identity of the reporting person should be kept confidential and be disclosed only with the consent of that person or by judicial process. A person acting in good faith who makes a report should be immune from civil and criminal liability.

A person required to report but who fails to do so should be liable for a fine.

One state agency should be responsible for receiving and investigating all reports. Each report received should be registered by the agency with all available information from the reporter.

The agency designated to receive and investigate reports should have a system and personnel to: Receive reports around the clock; keep records; have knowledge of services available; have access to services; have a state-wide mandate; and have the ability and trained staff to respond quickly.

A centralized intake system should be geared into a regional response system if possible.

The investigating agency should either provide services itself or coordinate service provision by subcontracting and referrals. This should be determined according to existing state service systems.

The initial investigation should be conducted by persons trained in human services.

Upon receiving a report made in accord with the law, the agency should investigate. This investigation should include a home visit and consultation with service agencies as well as contact with persons knowledgeable about the case (including the person making the initial report). The initial investigation for verification and assessment should be completed within a prescribed period of time such as 72 hours. The investigator should have access to a multidisciplinary geriatric team for consultation.

> If the report is not verified, the case is closed. Safeguards should be instituted to protect the accused.
>
> If the report is verified, an assessment of the individual's functional capacity, situation, and the resources available to the person should be made by a multidisciplinary team with expertise in the particular area of disability.

In conducting the investigation, the agency may seek the assistance of law enforcement officials and the courts. If access is denied to the investigator, either by the elderly or incapacitated person or by a caretaker, the agency may petition for a court order to enjoin interference with access to investigate. Such an order shall be issued upon specific facts showing that: (1) there is reasonable cause to suspect that the person in question is or has been abused, neglected, exploited, or abandoned; and (2) access has been denied to the representatives of the agency required to investigate such reports.

Regulations should be promulgated which assure continuity of case management for investigation, assessment, case plan development, and service provision.

Voluntary services should be provided upon consent to the elderly or incapacitated individual.

The service plan developed should provide for the least restrictive alternative, client self-determination, and continuity of care.

The services should be those which are necessary to prevent abuse, neglect, exploitation, or abandonment and should include medical care, mental health services, legal services, food, clothing, shelter, social services, and transportation.

A fair hearing procedure should be developed and implemented so that any service plan can be appealed on denial of application for specific services or for failure to provide the least restrictive alternative.

The agency should establish by regulation a sliding fee scale to be used in determining fees for services provided on a voluntary basis. However, no person should be denied services solely due to refusal to pay if it appears that the service denial will result in further abuse.

The agency should maximize all available federal reimbursements for such services. There should be no charge to the individual in question for the cost of the investigation on the assessment.

If an adult refuses services or withdraws consent, the agency must terminate intervention proceedings. This is consistent with the right of the adult to refuse treatment. The case is closed unless the agency seeks to provide services pursuant to involuntary provision procedures.

Standards of non-emergency involuntary intervention and services provision should include the following elements:

> Assessment of need and eligibility.
>
> Clear and convincing evidence.
>
> Least restrictive alternative; non-institutional placement where possible.
>
> Geriatric/clinical assessment by social worker, physician, mental health practitioner, lawyer to assure appropriate case plan and placement should be required prior to any request for a court order.
>
> Placement should not be in a mental institution, nor should any proceeding be a determination of incompetency.

Any involuntary service provision or placement should only be authorized pursuant to a court order after a hearing on the merits of the case.

The adult in question should be assured the right to counsel. If s/he is indigent, the court should appoint counsel. The adult should also have the right to be present and to cross-examine the parties involved. If counsel is waived, the court should appoint a guardian ad litem to act in the interests of the adult involved.

Adequate notice should be assured. The client and any interested party should be served, at least 14 days prior to the hearing, with a copy of the petition and notice, including an explanation of the proceedings; the date, time, and location; the proposed service plan; and the rights of tne adult in question to counsel, to be present at the hearing, etc.

The court order for any protective placement should be specific and include reasons for finding the placement necessary and a statement that the placement is the least restrictive alternative. These facts should be stated in the court record also.

The initial care plan submitted to the court should specify details of services, medical treatment, and relocation. The court order issued should be specific as to what services, treatment, and placement have been approved by the court. Any modification in the plan can only be made pursuant to court order.

The court should limit the order to 6 months or less. Upon court review, it can be extended for another period of time (up to six months).

The judicial determination authorizing involuntary intervention should be made according to the following: the adult bases decisions on delusions or hallucinations; is unable to make or implement decisions; or is unable to comprehend a decision's effect. The decision itself to refuse services should not be the sole evidence for finding the person lacks capacity to consent.

The costs for involuntary services should be borne by the state unless a court, after determination of financial ability, orders the client to pay or unless the client agrees to pay.

Standards of emergency involuntary intervention and service provision should include the following:

Emergency means that an elderly or incapacitated person is living in conditions which present a substantial risk of death or immediate and serious physical harm to him/herself or others.

A finding based on clear and convincing evidence that the adult in question is incapacitated and in need of services, and:

An emergency exists.
The person lacks the capacity to consent.
No one else can/is willing to consent.
The proposed order is substantially supported by the findings.

In issuing an emergency order, the court should adhere to the following limitations:

The court should specifically order only those services necessary to remove the conditions creating the emergency.

Hospitalization or change of residence should not be included unless specifically ordered by the court upon a finding that such action is necessary.

Emergency intervention should be limited to a period of 72 hours, renewable for 72 hours upon a showing to the court of necessity to remove emergency conditions.

The court may appoint a temporary guardian with responsibility for the person's welfare and authority to give consent for emergency services (as ordered by the court) for the duration of the order if necessary to implement the order.

The court should make sure that the elderly person is assured all rights except those limitations provided for in the order.

Access to the premises should be ordered by the court to carry out the order in cases where voluntary access has been denied.

Notice should be provided (including relevant and factual information on the basis of the petition) to the person, his/her spouse, children, next-of-kin, or guardian at least 24 hours prior to the hearing.

This notice may be waived upon a showing that: (1) immediate and reasonable foreseeable physical harm will result from the delay; and (2) reasonable attempts have been made to give notice to the above parties.

Emergency Placement: If it appears probable from the personal observation of a police officer that an elderly person will suffer immediate and irreparable physical injury or death if medical care is not provided, and that person is incapable of giving consent, and that it is not possible to follow the hearing procedures, the officer should be able to transport the person to an appropriate medical facility for medical treatment.

Notice of this action shall be given to persons listed above within 4 hours. A petition for emergency intervention should be required to be filed within 24 hours of this action and a hearing should be held with all due process guarantees within 48 hours of the transfer.

The same services available to victims should be available to the persons who have abused, neglected, exploited, or abandoned these persons. To meet this need, the state agency responsible for implementing the adult protective services system should develop formal cooperative agreements with other appropriate state and private agencies.

NOTES

1. *Virginia:* 63.1 Code of Virginia §§ 55.1–55.8. *Nebraska:* Laws §§ 28–1501 et seq. *Arkansas:* Arkansas Statutes of 1947 Annot. §§ 59–1301 et seq. *Alabama:* Code of Alabama §§ 38–9–1 to 11. *North Carolina:* Article 4A General Statutes of North Carolina §§ 102–108 et seq. *Florida:* Florida Statutes Chapter 77–336, §§ 409.3631 et seq. *South Carolina:* 43 South Carolina Laws §§ 29–10 et seq. *Connecticut:* 46a C.G.S.A. §§ 14 et seq. *Oklahoma:* 43 Oklahoma Statutes Annot. §§ 801–810. *Kentucky:* Kentucky Revised Statutes Chapter 209.010 et seq. *Tennessee:* Tennessee Code Annot. §§ 14–2301 et seq. *Maine:* 18 M.E.S.A. §§ 3601 et seq. *Montana:* Revised Codes of Montana 71–1914 et seq. *Michigan:* M.C.L.A. §§ 400.14. *New Hampshire:* New Hampshire Revised Stat. Chapter 161–D: 1 et seq.

Minnesota, Missouri, Arizona, and Vermont enacted statutes in 1980.

2. Statutes of Connecticut, Michigan, Oklahoma, New Hampshire, Virginia, Maine, and Washington.

3. Statutes of North Carolina, Florida, and South Carolina.

4. Connecticut is the only state that presently includes abandonment.

5. "Evidentiary Problems of Proof in Child Abuse Cases," 13 *Journal of Family Law* 819 (73–74).

6. Code of Alabama, § 38–9–5.

7. Id.

8. Florida Stat. Ch. 77–336, §§ 409.3631.

9. An example can be found in the case of *State* v. *Northern*, 53 S.W.W 2d 197 (Tenn. Ct. App.) *cert. denied, id.* (Tenn. 1978), *appeal dismissed as moot*, where the court held, in applying Tennessee's protective services statute, that although the individual was found to be "lucid and apparently of sound mind generally," she suffered from a delusion that rendered her unable to comprehend the gravity of her condition that required amputation of her feet to save her life (563 S.W. 2d at 209–210) (1978). She was judged legally incompetent to consent to the operation. The court authorized the "necessary" medical treatment without due regard for the right of the individual to refuse such treatment, or the apparent contradiction in their reasoning. For an almost identical case with the contrary decision, see *Lane* v. *Candura*, 36 N.E. 2d 1232 (Mass. Appeals Court 1979).

10. Not all states have articulated this as a principle and those which have mention it in the "legislative intent" section accompanying the statue.

PART IV—TRAINING AND PUBLIC EDUCATION

CHAPTER 9—TRAINING

Training should be a major component in any effort to assist abused and neglected elders. Elder abuse and neglect are "hidden" under reported problems, and few understand their scope. Because they are extremely complex problems, even fewer individuals have the background and skills needed to handle individual cases or to develop effective policy responses.

Those who work with elders often overlook elder abuse as a potential problem. The older person who "falls down a lot" may be suffering from more than the frailties of advanced age. Until workers are trained to identify and handle properly cases of abuse and neglect, the problems may continue to go undetected and unresolved.

Programs administrators also need training in elder abuse. They face difficult resource allocation decisions and will have to be educated about the nature and extent of the problem. They will also have to be persuaded of the need to develop treatment and prevent programs in cooperation with other agencies.

Advocates and activities must be kept abreast of both the current research and efforts at systemic change to involve them in the search for solutions.

State and local legislators must be reached. They must be presented with the facts and figures and offered sensible legislative recommendations.

In summary, training can serve too:

Increase general awareness of elder abuse.
Improve the capacity of service workers to assist abused elders.
Prepare administrators to develop responsive service delivery systems.
Stimulate activities and advocates.
Educate lawmakers about the problem and potential remedies.

WHO SHOULD BE TARGETED FOR TRAINING?

There are two basic categories of individuals who should receive training:

Those who provide services and have direct contact with the elderly.
Those who make or influence decisions on service delivery, fiscal allocations, and legislation.

Direct service workers may include:

visiting nurses
home health aides/homemakers
other in-home support service providers, e.g., drivers for meals-on-wheels programs
public health nurses
hospital social workers
hospital emergency room personnel
police
protective services workers
senior center staff
members of councils on aging
legal aid staff, lawyers, and paraprofessionals
family service agency workers
mental health center staff
nutrition program staff

Policymakers include legislators at the local and state levels and planners and administrators from direct service programs, planning agencies, legal services projects, and state offices concerned with aging, domestic violence, mental health, protective services, and law enforcement. Advocates and activists, such as the Gray Panthers, should be included in the policymaker category for training purposes.

WHAT KIND OF TRAINING SHOULD BE OFFERED?

Training sessions should be geared to the needs and interests of the audience. Care providers will want to know the nature of the problem, identification and investigation procedures, and intervention strategies. Presentations to policymakers might begin with an overview of the topic but should focus on systems issues such as resource development and legislation encompassing rights and remedies.

The following is a "menu" of training topics geared to the direct service provider:

Elder Abuse as a Component of Domestic Violence
Research on Elder Abuse: State of the Art
How to Identify and Assess Cases
How to Investigate Cases
Legal and Ethical Issues in Handling Cases of Elder Abuse:
    Access to Client
    Right to Privacy
    Confidentiality
    Client Consent
    Assessing Competency
How to Develop and Implement Pre-planned Responses
Elder Abuse as a Family Problem: Serving the Victim and Abuser
How to Inventory Resources and Services Gaps in Your Community
Avoiding Burnout

For an audience of administrators and legislators, the approach should focus on basic information and on developing local and state response systems rather than skills development. Topics might include:

An Overview of Family Violence and Elder Abuse
How Other States Have Responded to the Problem of Elder Abuse: Existing Statutes and Legal Remedies
Characteristics of an Integrated, Comprehensive Protective Services System
Assessing and Analyzing Resources and Service Gaps
The Limits of Current Knowledge and Directions for Further Research

With a diverse audience, it is possible to provide a mixture or topics. At present, most people need a basic introduction to the problem. Very few will find any of the proposed topics irrelevant or a repetition of what they know.

TRAINING DESIGN AND DELIVERY: WHO, WHAT, AND HOW

Training design is question of packaging—how should the material be organized and who should deliver it? This section covers a number of practical considerations:

Deciding on a format.
Identifying resource people.
Using the materials in this manual.
Tips for trainers.

Deciding on a Format

A training session can vary from a one-hour inservice workshop to a three-day residential conference. How long the session is and how the materials are presented will depend primarily on what the convenors hope to accomplish. Is the goal to increase general awareness about the problem of elder abuse? To impart skills to workers? To educate lawmakers? Carefully consider the goal of the session; then plan the right format to achieve that goal. Budget constraints, the number of participants, the setting, and timing will also influence the design of the training.

Identifying Resource People

Who can help to deliver the training? There are few experts in elder abuse treatment and prevention. You may want to check with the local university to see if any professors are doing related work or might be available to explain the highlights and limitations of existing studies. Directors of programs dealing with other forms of domestic violence, such as child abuse and spouse abuse, will have valuable experience to share. They may also find that their programs are handling some elder abuse cases. Individuals who have seen and handled cases of elder abuse, whether lay persons, social workers, or medical or mental health professionals, should be encouraged to make presentations. A lawyer who has researched relevant state laws should be included. A final suggestion is to use the materials contained in this manual and become an "expert" yourself.

Using the Manual

This manual presents much of what is currently known about elder abuse and neglect. Part I reviews the literature on elder abuse. Part II offers practical guidance to the direct service worker on handling individual cases. The protocols included are an invaluable model for developing pre-planned responses. Part III gives suggestions to policymakers on model delivery systems and legislation. Part IV addresses training and public education. Trainers should consider excerpting relevant portions for training sessions.

But one more publication will do little to protect the victims of elder abuse and neglect. It is up to individuals to use the information this manual contains to educate and mobilize their communities.

Tips for Trainers

The key to successful training is to pay careful attention to educational process as well as to substantive *content.* You should know your audience—their strengths, interests, and needs. Make your presentation clear and varied. There is more to training than having experts tell the audience what they know. Here are a few basic principles that may be of assistance:

Variety is the spice of life. The creative use of teaching techniques can transform a presentation. Appeal to as many senses as possible. Supplement mini-lectures with visual aids and handouts. Vary the size of the working group. Use techniques such as brainstorming and role plays to energize the group. Guide people through the protocols included in Part II. Use the hypothetical cases which follow the sample training agenda at the end of this chapter.

Establish a framework. Set the stage. Each presentation should have a clear introduction stating the purpose of the session, the areas which will be covered, and the format to be followed. A simple outline in poster or handout form can be helpful in this process. A brief summary of the session serves to reinforce learning.

Be prepared. Attention to logistics insures that things run smoothly and valuable training time is not wasted searching for materials, room numbers, electric outlets, handicapped-accessible bathrooms, etc.

Evaluate your efforts. Elicit trainee comments on the organization and content of the presentation(s) and on your teaching style. This can be done informally at the close of a session or by means of a written evaluation form.

Summary

Training can bring key actors together to educate themselves about a common problem and facilitate the development of cooperative solutions. There needs to be a shared recognition of the nature and scope of elder abuse and neglect. Those who work directly with elders need to be trained to identify cases and develop strategies for responding to emergency and chronic situations. Those who set program policy, allocate resources, and make law must be persuaded to respond to the problem of elder abuse and neglect in a comprehensive and coordinated fashion.

SAMPLE AGENDA FOR TWO-DAY TRAINING SESSION FOR DIRECT SERVICE WORKERS

Day 1

9:00–9:30—Introduction of Participants and Training Personnel.

9:30–10:30—Overview of Elder Abuse and Neglect: Summary of Data; Causation Theories; Family Context.

10:30–12:30—Adult Protective Services: The Nature of Protective Services Cases; Elements of the System; Identification of Abuse and Neglect Cases; Initial Assessment and Referral; Developing and Using Protocols.

12:30–1:30—Lunch.

1:30–3:00—Interviewing Techniques: Hypothetical Case(s); Role Plays.

3:00–5:00—Overview of Relevant Statutes and Legal Issues: Domestic Violence Statutes; Competency and Consent Issues; Access/Right to Privacy; Abuse Reporting Statutes.

Day 2

9:00–10:00—Systems Building/Interagency Cooperation: Professional Attitudes; Turf Issues; Dealing with Conflicts; Forging the Agreement.

10:00–12:00—Hypothetical Cases: Role Plays; Issue Spotting; Brainstorming; Protocols; Discussion.

12:00–1:00—Lunch.

1:00–2:00—Informal Presentation of Actual Cases.

2:00–3:00—Worker Burn-Out.

3:00–4:30—Developing Local Action Teams.

4:30–5:00—Evaluation.

HYPOTHETICAL CASES

Use of case profiles and hypothetical cases is an essential ingredient of the skills training social service, health, mental health, legal, and community workers need to handle elderly abuse and neglect cases. This section contains hypothetical cases to use in practicing with the protocols in Part II, Chapter 6, as well as additional hypotheticals for discussion and role play.

To get the best results from the hypothetical cases, the trainer should stipulate the applicable laws and available resources. The trainer can use either the laws and resources of a particular state or develop hypothetical laws and resources typical of the situations the trainee will face.

There are no set "answers" to the problems presented in the hypothetitcal cases, just as there are usually no easy short-cuts in handling real abuse and neglect cases. In these hypothetical cases, as in all abuse and neglect cases, there are numerous "logical" options to be carefully explored by the client and worker. Where no trainer with substantial experience is available to guide the group toward practical solutions the training group should "brainstorm" answers together.

Role play should be included in working through these cases. Role play is a highly effective, multipurpose teaching technique that can be used in many different ways. It is particularly appropriate for direct service workers handling abuse cases since it dramatizes the subtleties and complexities of human interaction. Role play has a number of other advantages. It can:

Create involvement and commitment on the part of the trainees by requiring active participation.

Serve as a bridge between theory and action, enabling trainees to make an effective transition from understanding to practice.

Provide a safe learning environment where new approaches and behaviors can be tried out without the consequences of failure.

Make actual, concrete behavior available for analysis, feedback, and improvement.

Help trainees overcome prejudices and strong emotional reactions.

For example, a role play that encourages empathy and understanding for both abuser and victim can help direct service workers escape the impulse to stereotype and instead understand and evaluate accurately the dynamics of a family situation. This could be achieved by breaking the trainees into groups of three, with each person in a group playing in turn the interviewing worker, the abuser, and the victim. Later the groups could reassemble to share feelings and observations.

CASE NO. 1: CONSENTING, COMPETENT CLIENT

James Dolan, a 70 year old retired draftsman, lives with his daughter-in-law, Marie, and grandchild in a small, run down house owned by his son, James Jr. Mr. Dolan suffers from debilitating arthritis of both knee joints and walks slowly with a walker.

Mr. Dolan's arthritis has gradually worsened since his retirement five years ago. Three years ago, after several bad falls, he agreed to sell his own home and move in with his son and daughter-in-law. Mr. Dolan turned the proceeds from the sale over to his son. Since that time, Mr. Dolan has lived in a small (9' x 11') converted sewing room on the second floor of his son's house.

While Mr. Dolan can care for himself in general, he does so with great pain. He has difficulty completing precision tasks, such as cutting his food or shaving, because of some swelling in his fingers. He enjoys reading and in the past has often asked Marie to bring him books from the town's library.

Last year, James Jr. left his wife and withdrew most of the money from their joint savings account. He continues to provide some support but moves around frequently and has given no clear indication about the future status of their marriage. James Sr. remains in the house with his daughter-in-law and grandson.

During the past year, Marie has gradually withdrawn from all social contact. Last month she removed her 4 year old son from the day care center he attends. She has also stopped most care for her father-in-law, who remains isolated in his room, and who frequently goes without meals.

Last week, Mr. Dolan, frustrated and lonely, dressed himself as best he could and managed to get downstairs with great difficulty. Marie found him in the front yard and ordered him harshly back into the house. When he fell, Marie did not help him up.

A neighbor who witnessed the fall offered to help Mr. Dolan upstairs. Marie declined the offer, saying, "If he got down himself, he can damn well get back up there too." and asked the neighbor to leave her yard. Mr. Dolan, apparently in pain looked at the neighbor and said, "Can you help me?" The neighbor, concerned and frightened, called the welfare department and asked what could be done to help "the old man". "He doesn't look so good," said the neighbor. "I think he hurt himself when he fell." The neighbor indicates that Mr. Dolan has asked for help before. The neighbor also said she was fairly certain the daughter-in-law will deny access to Mr. Dolan.

CASE NO. 2: COMPETENT, CONSENTING CLIENT[5]

Mrs. Georgia Vickers is a 65 year old, recently retired clerk who lives with her 68 year old husband, Thomas, in a single family house which they own (though the title is only in Mr. Vickers' name). The couple have three adult children but only one, Matthew, lives nearby. During an infrequent visit Matthew Vickers witnessed an argument between his parents. In the course of the argument Mr. Vickers slapped his wife because she would not stop "complaining". Matthew intervened and was then ordered from the home by his father. This was not the first time that Matthew had observed his father hit his mother; however, he now realized that his father was becoming increasingly violent and dangerous.

The next day Matthew Vickers telephoned the local Area Agency on Aging because he wanted to know what kind of help was available. The AAA referred him to Mid-State Home Care Corporation. The intake worker listened to his story and explained what services the agency offered. The worker suggested that a case manager make a home visit to do an assessment, but she indicated that this could take place only with the client's consent. Matthew telephoned his mother and told her what he had done and asked if she would be willing to have an assessment interview. She agreed to meet with the case manager but not in her own house because she feared her husband's reaction.

Mrs. Vickers set up a time to meet with Rita Catalpa, a Mid-State case manager, at Ms. Catalpa's office. During this initial interview it emerged that Mrs. Vickers had been the object of emotional abuse for years. The physical blows were a comparatively recent thing, but they caused Mrs. Vickers an enormous amount of grief. Mrs. Vickers explained that, despite her anxiety and unhappiness, she had done nothing because she feared the loss of her house. Not only the house but all bank accounts and insurance policies were in Mr. Vickers' name. Mrs. Vickers said that she knew her husband well enough to know that if he were provoked, he would try to seize all of it, just to frustrate her.

Catalpa listened to Mrs. Vickers' recitation of abuse and threats and promised to try and help her find a solution. She explained that cases such as Mrs. Vickers might be complicated, and sometimes require help from other professionals. Rita Catalpa asked Mrs. Vickers' permission to speak with an attorney about possible alternatives. Mrs. Vickers consented on the condition that she remain anonymous.

Catalpa met with Leslie Miller, an attorney from the local legal services project. She explained Mrs. Vickers' problems to Miller and was candid about the older woman's fears of material loss. The attorney explained the Domestic Violence Act provisions and how the act might be applied to protect Mrs. Vickers' person as well as her property. Miller noted that the client could petition the court for a temporary restraining order, a vacate order, and an order for temporary support. The attorney also pointed out that the client might consider divorce proceedings, establishing her right to some of the property through a divorce settlement. In either case, though, the client would have to confront her husband in a courtroom and she might suffer a temporary loss of economic support.

After her meeting with Miller, Rita Catalpa telephoned Mrs. Vickers. The couple had just ended another argument during which Mr. Vickers had struck his wife and pushed her into a wall. Mrs. Vickers was very upset and begged Catalpa to "do something". Catalpa asked Mrs. Vickers if she would speak to an attorney. When Mrs. Vickers agreed, Catalpa called Miller and asked if it would be possible to meet at the client's home. Miller said she would rather interview Mrs. Vickers privately at her office. Catalpa agreed to drive Mrs. Vickers to the legal services office.

Having talked with her attorney, Mrs. Vickers decided to petition the court for a vacate order and an order for temporary support. Miller suggested that Mrs. Vickers might not want to be alone when her husband was served with the court order to appear for a hearing. Miller called Catalpa and asked for an emergency placement for her client until the hearing had occurred. Catalpa explained that the town really had no provisions for housing emergencies.

COMMENTS TO TRAINER

There are at least three possible conclusions to this case:

(a) The court may grant Mrs. Vickers' request and her husband will have to move elsewhere. Mr. Vickers will have to pay support.

---

[5] This case is designed for a non-community property state that has a Domestic Violence Act.

(b) The court may grant the petitions but Mrs. Vickers may agree to attempt a reconciliation with counseling support. (In this case, the restraining order acts as an insurance policy for the client while she continues to live with her husband.)

(c) The court may refuse to grant petitions. Case management then would have to deal with Mrs. Vickers' need to protect herself.

CASE NO. 3: COMPETENT/NON-CONSENTING CLIENT

Gretchen Anderson is a 75-year-old widow who worked for twenty years as a waitress. Mrs. Anderson has lived with her 50-year-old son Mitchell since he was released from Bryce State Hospital five years ago. Mitchell had been committed by his estranged wife when he was 35 and actively psychotic. He spent the next ten years of his life medicated on a chronic care ward. During the deinstitutionalization process, a hospital social worker arranged community placement in a foster care home. The house parents were intolerant of Mitchell's lapses in hygiene. Mitchell's mother, an increasingly bitter and suspicious woman since retirement, agreed that her son could share her apartment so long as he paid his share of expenses.

The two lived together with only minor difficulties until a year ago when Mrs. Anderson was terminated from the Supplemental Security Income (SSI) program because her bank account exceeded her resource limit. Mitchell's aftercare social worker from the state hospital offered to help Mrs. Anderson but she initially refused. When her bank balance had dropped very low, however, she telephoned the aftercare worker, Bruce Stevens, and asked for help. Mrs. Anderson had begun "borrowing" money from Mitchell's disability checks and he sometimes became argumentative about his mother's tampering with his money. Mr. Stevens refers Mrs. Anderson to the Adult Protective Services office for assessment and SSI advocacy.

Ellen Jackson, a case worker, visits Mrs. Anderson after a brief telephone consultation with the state hospital worker. Jackson begins asking Mrs. Anderson some general question when Mitchell enters the living room. He stands and slowly rocks back and forth until the case manager starts touching on financial issues. As Jackson asks a question, Mitchell says to his mother, "Don't answer that." Jackson smiles at Mitchell and explains that Mrs. Anderson has already answered these questions once in order to get SSI. Mitchell becomes more defensive and again pleads with his mother not to answer. Finally, when Gretchen Anderson attempts to tell her current bank balance, Mitchell becomes very defensive, runs around behind his mother's chair and roughly covers her mouth with his hand. "Don't tell her anything. She wants to send me back. I know she does. I'll kill you if you tell her!"

Jackson, fearing for both herself and her client, rises slowly to leave. She says in as steady a voice as she can muster, "I must go now, Mr. Anderson. Why don't you let go of your mother? I don't want to hurt either of you. See, I'm even leaving the papers we were filling out here." As she moves toward the door, Mitchell releases his mother, who now has a cut lip. He is still clearly agitated. Mrs. Anderson transfers all her anger to Jackson and screams at her to get out and leave them both alone.

Immediately after leaving the Anderson apartment, Ellen Jackson drives back to her office and calls Bruce Stevens. Jackson tells Stevens what has just happened and asks if Stevens can pay a quick visit to the Anderson house to try to defuse the situation. Stevens does so and is refused admittance by an angry Mitchell. Behind Mitchell, Stevens sees Mrs. Anderson holding her side and shouting, "Leave us alone."

Stevens returns to his office and calls Ellen Jackson. Jackson asks whether Mitchell can be readmitted to the state hospital or nearby community mental health center for psychiatric evaluation. Stevens counsels against such action, saying that this is the first such occurrence of aggressive behavior since Mitchell's disastrous experience in a foster care setting. He also points out that the uproar seemed inadvertently to be the result of Jackson's visit. Stevens further notes that neither Mitchell nor his mother have asked for help and that readmitting Mitchell may make matters worse for Mrs. Anderson from both an emotional and a financial point of view.

Jackson reluctantly agrees with Stevens but continues to press her concern for Mrs. Anderson. Stevens notes that he has another regularly scheduled visit to the Anderson home coming up in a week. He offers to act as a link with the Adult Protective Services providing Jackson is willing to coordinate services through him. Stevens suggests that Jackson develop some service care plan alternatives for Mrs. Anderson as well as investigate emergency financial and shelter possibilities. Jackson consents to Stevens' suggestions and they propose a joint conference after Stevens' next visit to the Anderson's.

CASE NO. 4: COMPETENT, NON-CONSENTING CLIENT

Helen Morrissey is an 86-year-old woman of independent means and spirit who lives with her niece Anna, aged 68. Anna is a slightly bewildered diabetic who dotes on her frail, bedridden aunt. They live in a large house in what has become a seedy area of town. There are frequent break-ins in the neighborhood and Anna fears being mugged. She has taken to locking doors against most callers and only goes out once a week to do shopping and errands.

Helen has noticed Anna's increasing obsession with possible harm and has sometimes suffered because of it—Anna frequently postpones shopping trips for days on end because of her fear of going outside. As a result, food supplies run dangerously low and meals are sometimes skimpy. Helen fears that someday Anna, who is becoming forgetful, will not take her medication and go into a coma. Helen knows she could not help Anna if this happens. As a precaution, she has the telephone moved to her bedside, within easy reach.

A friend visiting Helen for the first time in several months notices her drastic weight loss and the sloppy condition of the house. She raises these issues with Helen only to be told, "Mind your own business, deary. Anna and I have been together for 14 years and I'm not going to change things now."

The friend, still concerned, calls the local agency which provides in-home supportive services and asks them to talk to Helen. The case manager calls and Helen tells her to "butt out" and bangs up.

A few weeks later, the case manager receives another call from Helen's friend and is informed that Anna was hospitalized a week ago in a diabetic coma. Anna is recovering and Helen, now being cared for by the friend, still refuses to consider a change in her life style. Anna insists she is well and must soon return home to care for and protect Helen. Helen's friend is very worried.

CASE NO. 5 EMERGENCY

The Ashton police department referred Mr. Luther Hodges to the welfare department after it had received an anonymous telephone call about an elderly man supposedly living in an abandoned house. The police officers sent to the address reported that they discovered a man of approximately 70 years who appeared to be living alone in an almost empty five-room house with only a few pieces of dilapidated furniture. The man, who identified himself as Luther Hodges, said that he had been living with his son and daughter-in-law since his wife died two years before. Mr. Hodge's son had decided to take a ship building job in Virginia and he had specifically rejected the idea of taking his father along. One of the officers asked Mr. Hodges if he wanted to speak to a social worker and Hodges refused the offer.

Two days after the initial report, the Ashton police received another call about Mr. Hodges, this time from the owner of the house. The owner indicated that he has sold the property where Mr. Hodges currently lived and that development was to begin within a week. Before returning to the house, the police contacted the welfare department and asked if a worker could accompany them on their visit to Mr. Hodges. The case management supervisor agreed to assign a worker but noted that police presence beyond the initial introductions and the explanation of the problem might be counterproductive. While the police accepted this provision, they pointed out that Mr. Hodges was soon to be in violation of the law.

Ralph Yates, the worker assigned to the case, arrived at Mr. Hodges' house with the police Tuesday afternoon. The police explained to Hodges that he was living in a house which would be demolished in a week and that the owner of the property would take legal action to remove him if that were necessary. After introducing Yates, the police departed.

As the interview proceeded, Hodges emerged as a somewhat defiant 75 year old man who fully expected his son to return for him any day. He admitted that they had argued previously but he seemed unable or unwilling to grasp the idea that he had been abandoned. Hodges did not know his son's new address nor was he sure what sort of benefits he received because his son or daughter-in-law had always handled his checks. He had only five dollars on him and was uncertain about whether he had a checking or savings account. Yates explained that at least until Mr. Hodges' son did contact him, it might be wise to explore some alternative living arrangements. Hodges explained that he could not leave "his" house because he had no money and his son would return to that location looking for him. Yates said that he could help with emergency funds and that neighbors could be alerted to look out for Mr. Hodges' son. Yates also promised to help with filling out a change of address card for the postman. Finally, Yates reminded Hodges that ultimately the police would force him to leave anyway. Despite this, Hodges refused to leave.

CASE NO. 6: EMERGENCY (COMPETENT/NON-CONSENTING)

Mrs. Grace Lovins is a 68 year old woman who has been a client of the welfare department for approximately two years. The client is a recovered alcoholic with some brain damage who smokes cigarettes incessantly. She has periodic lapses in sobriety usually associated with reactive depression or stress. Mrs. Lovins first became a welfare client in 1977 after a fire destroyed the apartment building where she had lived. The Welfare department assisted by re-housing her in an elderly building and has maintained monthly case management visits for client monitoring since that time. Chore services have been arranged on an as-needed basis.

Mrs. Lovins is a dependent and sometimes confused person. She is generally able to focus on people but has trouble with time and place. She has occasionally gone out unescorted and been unable to find her way home. She once sat in a hospital waiting room for ten hours because the Senior Transportation Van neglected to pick her up.

Mrs. Lovins has had the same case worker since the fire. Carolyn Jones, the worker, genuinely likes her client though she admits to some uncertainty about Grace's coping abilities. The only other significant person in the client's life is another resident of Grace's building, a wheelchair-bound former alcoholic named Peter Simpson. Mrs. Lovins variously refers to him as her "boyfriend" or her "drinking buddy". Since both have been known to get drunk and engage in violent arguments, the other residents of the building rarely interact with them. Jones has never determined how aware the client is of her extreme isolation. Peter is frequently hospitalized and has asked that Grace visit him. She refuses to go because of a long-standing fear of hospitals complicated further by her previous experience of being left in the waiting room.

Mrs. Lovins has complained lately about abdominal pains and Carolyn Jones has tried to get her client to see a doctor. The worker has suspected an ulcer aggravated by occasional drinking. Mrs. Lovins is adamant in her refusal to seek medical care.

Jones received a frightening telephone call from Mrs. Lovins this morning begging the worker to come and visit. Initially suspicious that her client was lonely and possibly drinking, the worker refused, but since she had two other clients in the same building to reassess, she finally agreed to "look in" for a few minutes.

When Mrs. Lovins answered the door, Jones was shocked by her appearance. The client wore a blood-stained house coat and looked as if she might pass out any minute. $300 was scattered on the kitchen floor. Jones could not get an explanation from her client about the money or the blood stains. As the client walked unsteadily, she trailed drops of blood. Mrs. Lovins was inarticulate with fear and embarrassment. She refused Jones' offer of an ambulance.

Unclear about what to do, Jones called her supervisor. In the meantime, Mrs. Lovins lay down on her couch with a cigarette and was moaning. Jones' supervisor said that he could offer no suggestions but that if Jones did call the ambulance, it was her responsibility.

CASE NO. 7: INCOMPETENT, EMERGENCY

Mrs. Marvis Riley is an 80-year-old woman who lives alone in an indescribably cluttered apartment on the third floor of a two-family house. The widow of a fire fighter, Mrs. Riley has an adequate income derived from Social Security and her late husband's pension. The client has lived in this same apartment for the past thirty years. The house had previously been owned by Mrs. Riley's brother; however, he sold it to a Reverend Anderson, a Methodist minister, ten years ago. The brother, now 90 and quite frail, lives in a suburb. He has not seen his sister in seven years. The only other known relative is a 53-year-old daughter, Diane, who lives alone in a nearby industrial town. Diane currently works in a fish processing plant. She has a history of past mental hospital admissions and copes marginally with life. Diane is her mother's only link with the outside world and her weekly visits are the client's sole means for obtaining food on a regular basis.

According to Diane, Mrs. Riley has always been a strong-willed, rather eccentric woman. Two years ago, however, the client was robbed on the street and beaten badly. After six weeks in the hospital, she returned to her house. Upon her return or shortly after it, the client's behavior became increasingly erratic. Mrs. Riley began refusing to pay Reverend Anderson the rent because she claimed that her brother owned the house and "*he* never charged any rent!" Anderson's sense of responsibility initially prevented him from doing anything to recover his losses. He has now filed for eviction, but only after Mrs. Riley failed to pay her rent for the twelve months. Mrs. Anderson, a former social worker, has become increasingly concerned about Mrs. Riley's effect on her two pre-adolescent children. Mrs. Riley has frequent screaming conversations with herself and she is occasionally assaultive. Reverend Anderson recently left a case of canned soup in his tenant's kitchen while she was napping; she responded to this by throwing the cans of soup in the direction of the children as they returned from school.

Mrs. Anderson contacted the senior health and home services program about one month before the eviction papers were filed. She explained the case professionally and admitted some of her own ambivalence. Mrs. Anderson said that Mrs. Riley ought to have enough money to acquire new housing since she hadn't cashed her benefit checks in over a year. Mrs. Anderson did agree that it would be difficult to find anyone who would put up with the tenant's behavior, but she felt that her family had borne the burden of Mrs. Riley long enough. Mrs. Anderson offered to help the home care worker with access and information; however, she was adamant that nothing, not even her profound sense of personal sadness, would forestall the eviction, even if that meant hiring a constable and/or calling the police to enforce the eviction notice.

Maryanne Bluesky, the case worker assigned to Mrs. Riley, makes three attempts to see the client. On each occasion the client refuses to open the door. Finally, Bluesky is admitted with Diane after one of the daughter's weekly shopping trips. Mrs. Riley is confused. Her thoughts are loose and tangential, but she seems to be able to check the groceries which Diane has purchased. On a radiator sits mouldering a pan of Duncan Hines brownie mix. Bluesky ultimately gets the client to agree to see her and a "doctor" within a week.

When Bluesky and her psychologist consultant, Dr. Tanaka, arrive on the following Tuesday, Mrs. Riley refuses to let them in. She says that they've come on the wrong day; they were "supposed to come on Tuesday." Bluesky gently reminds Mrs. Riley that it is Tuesday. "Not in this apartment, it isn't," shouts Mrs. Riley as she slams the door. Dr. Tanaka looks at Bluesky and says that the visit is a waste of time and that she will only see Mrs. Riley in her office—and why do case managers always give her such rotten referrals anyway?

Bluesky sets up an appointment with Diane Riley to discuss the possibility of a guardianship for her mother. Diane becomes very emotional during the interview and says that she's fearful of losing her job if she has to take off any more time on her mother's behalf. She tells Bluesky not to call her at work any more because her foreman has complained about it. When Bluesky telephones Mrs. Riley's brother, he says that he wants nothing to do with his sister because "Marvis is crazy . . . always has been." The eviction is scheduled for the next day at 8 A.M. Mrs. Anderson has sent her children away to avoid the scene. She has alerted the police and plans to have her attorney present.

CASE NO. 8: POSSIBLE INCOMPETENT CLIENT

George Simpson, an 81-year-old retired drapery maker, lives with his 75-year-old sister, Agatha, in a building for older people. Because of multiple physical ailments, Mr. Simpson has been hospitalized three times in the past six months. His follow-up care has included visting nurse treatments twice each week since the initial hospital stay.

In the past two months, Mrs. Turner, Mr. Simpson's nurse, has noticed a significant drop in her patient's level of functioning. Mrs. Turner is concerned not only with Mr. Simpson's mental state, but also with unexplained bruises and scratches which she has noticed during several examinations. As the older man has grown more dependent, his sister seems more intrusive and demanding. An increasing amount of Mr. Simpson's care has become Agatha's responsibility. She clearly resents the responsibility and openly ridicules her older brother for his increasing dependence.

At Mrs. Turner's suggestion, Al Torelli, a protective services worker from a private agency, begins visiting Mr. Simpson. After a month of casework, however, Mr. Simpson has not acknowledged that there is any problem with abuse and declines further visits. He does agree that Torelli may call his only other relative, a son named Henry who lives in New York City.

Torelli informs Henry of the situation. Henry Simpson decides to hire an attorney to move for guardianship in order to place his father in a nursing home. When George Simpson receives notice from the court about the guardianship hearing, he becomes furious. He accuses both his sister and his son of "tormenting" him. Mr. Simpson asks Torelli to help him fight the guardianship. Torelli believes that a nursing home placement would be harmful, but is not certain whether the problems in the home can be solved.

CASE NO. 9: FOR CASE WORKER-CLIENT INTERVIEW ROLE PLAY

You have been asked to role play a client named Mrs. Mattie Vernon. Mrs. Vernon is a 74 year old widow who lives with her disabled son, John, in a single family house. Mrs. Vernon has one other child, a married daughter named Susan, who has an apartment in the same town. Mrs. Vernon has been diagnosed as having a congestive heart condition. John, a Korean conflict veteran, has diabetes and a suspected drinking problem. Both people receive SSI, John for his disability and his mother for old age. They have been recipients of four hours homemaking each week for the past two years and John Vernon receives diabetic home-delivered meals.

Approximately one month before the upcoming interview, John was admitted to a local hospital for bi-lateral, below the knee amputations. He has been a troublesome patient and very unpopular with the staff. The hospital discharge planning staff strongly oppose returning John to his mother's house. They point out her age, heart condition and the two-story construction of her house as reasons for placing John in an accessible (and possibly supervised) site. John has adamantly refused to discuss living alone in a handicapped apartment unit or in a nursing home. Despite being confined to a wheel chair, he wants to return to his mother's house. His sister, Susan, wants nothing to do with John and only goes to the hospital to accompany Mrs. Vernon.

Mrs. Vernon has agreed to meet with her case worker to try and work out after-care plans. She does not want her son to return, but she really is afraid of him. The day before this meeting John Vernon told his mother, "I'll get you, if you let them put me in a nursing home."

CASE 10: FOR ASSESSMENT

Mrs. Carmella Santos is 85 years old and lives with her 89-year-old husband Paul and their daughter Ruth. Ruth was diagnosed as mildly mentally retarded in her childhood. She has never lived anywhere but with her parents. Both Mr. and Mrs. Santos are proud that their daughter was never institutionalized. Paul Santos is a retired butcher with emphysema and a recent history of three mild strokes. He speaks in a whisper and often has alarming coughing spells. The visiting nurse once described Mrs. Santos as being on the verge of falling asleep after a lifetime of weariness.

The Santos household receives twelve hours of home-care service each week. Both the homemaker and case manager have urged that Ruth Santos take more responsibility in caring for her parents. Despite their suggestions, however, Ruth seems established in her dependent, child-like role. She has given no indication of any desire to act more independently. Mrs. Santos wearily says, "I'd rather cook for her than argue with her." Paul Santos has never been involved with his children. He tends to remain aloof from them except on formal occasions such as major holidays and weddings.

Several months ago Mrs. Santos' case manager, Rachel Matthews, noticed dark bruises on Mrs. Santos' arm. When asked about them, Mrs. Santos said that she really couldn't remember but that she thought she might have fallen against her towel bar. Some weeks after that, Matthews received a phone call from the Santos' homemaker. The home aide said that she had seen Ruth punch Mrs. Santos when she dozed off during a conversation. The homemaker has tried to talk with her client about the problem but Mrs. Santos is very protective of Ruth. Mrs. Santos harbors an almost morbid fear that Ruth "might be put away and get pregnant."

The other Santos child is a son, Richard, who lives in Palo Alto. He has made no secret of his desire to institutionalize Ruth so that his mother "can finally rest." Mrs. Santos has begged her homemaker never to mention the bruises to Richard. The homemaker initially agreed to keep Mrs. Santos' confidence but changed her mind when the bruises continued to appear. Richard Santos is due to visit for his mother's birthday in two months and Mrs. Santos is fearful of his arrival. Recently, Paul Santos has been admitted to Catholic Memorial Hospital with complaints of chest pains.

CASE NO. 11: FOR ASSESSMENT

Mrs. Jessica Mattigan is an 81 year old Parkinson's victim who lives with her son George in a house which she owns. Mrs. Mattigan has been a client of Adult Protective Services for approximately one year. Because she has $10,000 in the bank, she has received limited service. A case worker did, however, assist with locating a geriatric day program which Mrs. Mattigan pays for and attends daily.

Even though Mrs. Mattigan uses a walker, she has frequently showed up at her day program bruised. At least once she fell so badly that stitches were required. Both the day program bus driver and the program nurse have expressed concern. The nurse has some questions about the client's ability to live independently without more skilled supervision. She has also noted that some of Mrs. Mattigan's bruises are on the face and forehead; less likely injury locations for a person who uses a walker.

Approximately one month ago son George lost his job as a dispatcher with a local trucking company. He claims that getting his mother ready for the day program caused him to be chronically tardy. The homemaker believes that he was fired for drinking on the job. Since his dismissal, Mrs. Mattigan's condition has deteriorated considerably. There are new bruises every two or three days and the nurse has questions about whether the client is getting her medication on schedule in the correct amounts. Further, Mrs. Mattigan has unaccountable outbursts of weeping.

The caseworker has raised the issues of nursing home placement. Mrs. Mattigan is inclined towards it. George opposes it. He wants to remove his mother from the day program and care for her at home. George maintains that since he is not working it is foolish to "waste money on the day program." Neither the program nurse nor the caseworker believe George is able to care for his mother. Regardless of their objections, though, George has threatened to seek guardianship of his mother in order to stop placement.

Despite Mrs. Mattigan's general assent to nursing home placement, her son's opposition clearly troubles her. Thinking that George's opposition stems in part from his fear that his inheritance might be consumed to pay nursing home costs, the caseworker attempts to explain the Medicaid rules. George Mattigan interrupts by saying, "You cannot tell me about rules and laws and what they mean." His refrain is, "I want my mother to stay at home with me. I can take care of her."

CASE NOS. 12–15: PROFILES TAKEN FROM COURT RECORDS

No. 12

After a divorce, Laura Webly, a middle-aged woman, moves in with her parents. The parents accept her presence and life settles into a fairly normal pattern. Shortly after her arrival, the parents go away for a few weeks of hard-earned vacation. They call back once a week to make sure everything is fine. On their return they find that Laura has systematically looted the home, selling everything of value. Their safe deposit box is empty. Laura has fled with the car.

No. 13

Marie, an 84-year-old woman, came home from a hospital after hip surgery. A next-door neighbor was made conservator for Marie. The conservator prohibited Marie's banker, lawyer, and friends from seeing her. There was evidence that mail and messages intended for Marie never reached her. The conservator also refused access to visiting nurses.

After receiving complaints from Marie's banker and lawyer, a superior court judge ordered a city police officer to accompany a mental health caseworker into the home. After seeing the court order, the conservator opened the home. Marie was interviewed extensively. Her main complaint was that her next-door neighbor/conservator was attempting to "shut me away." She trusted the conservator but could not understand her mania for secrecy.

After two subsequent court appearances, Marie was placed temporarily in a nursing home and a new conservator was appointed. Marie was then placed back in her own home where she received in-home care and health visits arranged for by the mental health district. The neighbor did not cause further problems.

No. 14

Ellen, a developmentally disabled older adult, had inherited a trust from her parents. The trust was administered at the discretion of two trustees who had institutionalized Ellen in an adequate board and care facility.

After several years, authorities discovered that Ellen was receiving SSI while her savings account was in excess of $400,000. No portion of the $400,000 was being used to support Ellen.

The county social worker and a welfare investigator interviewed the trustees and found that the trustees were living on the interest derived from the account.

Ellen was taken out of the institution and placed in a small board and care facility shared by some of her friends. The savings account financed the move and her care. The case of embezzlement and welfare fraud against the trustees is still pending in criminal court.

No. 15

Roger, a middle-aged man, took care of his 70-year-old mother. They lived in his home—an apartment in a very good area of town. Roger had been declared his mother's guardian and he used her pension to care for her needs.

Several years after the mother moved in, Roger lost his job. He fired the housekeeper/attendant and began to care for his mother alone. The mother appeared periodically at a medical facility to be treated for abrasions on her face and mouth. On a visit to the home, a visiting nurse discovered the woman had broken an arm. Roger said he slipped while helping his mother from the table, causing her to fall. He said he was happy to care for his mother who, he said, had shown him "great affection" as a child.

The visiting nurse had the mother hospitalized and called in a court-appointed social worker. After interviewing the mother and son for many hours, the worker created a trusting relationship with the mother. The client finally admitted abuse by her son and asked for help. She said that Roger, an intimidating person, believed he was doing a good job in caring for her but that he believed she needed frequent slapping as a form of "discipline."

The judge in the case called a court session and lifted the power of guardianship from Roger. The social worker called in various service providers and had the mother placed in a private nursing home.

Roger, even after intensive therapy, remained isolated. It was discovered that his mother had abused him as a child. His abuse of her had become a form of revenge. In the words of a court investigator, "he had unresolved hatred of his mother based on childhood events."

CASE NO. 16: FROM THE RECORDS OF A VISITING NURSES ASSOCIATION

A visiting nurse was assigned to an older woman who suffered periodically from malnutrition and dehydration. Once inside the home, the nurse discovered that the caretaker son withheld food and water as a way of controlling his mother and making her acquiesce to his demands.

The abuse included deliberate inattention to the mother's personal hygiene. The nurse attempted to compensate by training the son to care for his mother.

Subsequently, the nurse got a call from a neighbor who had visited the old lady. According to the neighbor, the older woman's arm was "swelling." The nurse called in two physicians with a mobile X-ray machine. They discovered a broken arm. The nurse then went to the probate court and had the woman removed from the house to a nursing home.

CHAPTER 10—BUILDING COMMUNITY AWARENESS THROUGH PUBLIC EDUCATION

Elder abuse and neglect remain unrecognized problems in most areas. A well-organized public education effort can shape and inform the public's perception of these problems which in turn can strengthen efforts to establish treatment and prevention programs.

An organization or committee working in this area should consider using public education as part of its overall strategy.

As a first step, the group should appoint an education coordinator in charge of arranging for talk shows, contacting media representatives, writing public service announcements, etc. If another public education program in the community addresses elder abuse and neglect, the education coordinator should attempt to develop a joint strategy with those working in that program.

There are several possible short- and long-term goals for a public education campaign on elder abuse. They include:

Providing basic information on the facts of abuse and neglect.

Encouraging elder abuse victims and their families to seek help.

Persuading service providers to develop a more effective protective service system.

Publicizing the beneficial impact of multidisciplinary cooperation.

Linking elderly abuse to other forms of family violence to generate comprehensive services for all forms of domestic violence.

Sensitizing the community to the special problems of particularly old and/or disabled elders.

Affirming the right of older people to basic forms of care.

Educating reporters and media staffs about elder abuse and neglect and their impact on the community.

The education program will probably begin slowly. Some people working in the elderly abuse field may feel the program will drain valuable resources from direct care efforts. It is the task of the education coordinator to emphasize the critical role public education must play in any serious effort to address elder abuse and neglect. The coordinator can cite as an effective example the lengthy and vigorous education campaign that was necessary to convince society to confront the problem of child abuse.

PUBLIC PRESENTATIONS

The education coordinator should consider arranging for experts to address concerned groups of citizens. A single expert can deliver a speech or several exports can offer comments and answer questions in a panel format.

Often, however, there will not be experts available to attend all the presentations the education coordinator can arrange. Members of the group can make the presentations themselves if properly prepared. This means the education coordinator should work with experts to prepare one or more basic speeches for delivery by group members. It is not necessary to be a thoroughgoing expert to discuss the basic problem of elder abuse and neglect intelligently. The speech plus this manual should enable group members to make effective presentations to citizen groups.

There are a few general guidelines to consider in preparing and presenting a talk on elder abuse and neglect.

Approach leaders at senior centers, churches, service clubs, and business groups, and ask to speak at their meetings. Don't wait for community leaders to approach you.

Have a member of the group you will address advise you on how to tailor your speech to the group's needs and activities.

Advertise the speech in appropriate ways prior to the event.

Make it simple. In discussing an issue for the first time, emphasize one or two key concepts. Develop those concepts and summarize. Use handouts or audiovisuals for emphasis.

Assume that no one in the audience knows about the problem. This will prevent you from "turning off" potential listeners. Everyone who is interested in family violence can gain from a good presentation.

Avoid criticizing service providers in remarks made to a general audience. Be positive in affirming the need for treatment and prevention.

USE OF THE MEDIA

Abuse of the elderly is an emotional issue. Many professionals working with the elderly justifiably fear media exploitation of their clients who are interviewed by reporters. Yet the answer is not to shun the media. Rather, there is a need to explain the problem to reporters while keeping them from sensationalizing particular instances of neglect and abuse. The media can act as an advocate for the elderly and serve as an important public education resource.

In fact, the media will inevitably define the issue for the mass audience. It is therefore in the best interests of service providers, action committees, and other organized groups to stay in direct contact with the local media representatives to help assure informed, responsible coverage. This can be accomplished in several ways. The education coordinator or other knowledgeable individual should approach local reporters with information, volunteer to give press briefings, and act as a on-call media source.

Most reporters are unaware that violence against elders exists in the home environment. Having been briefed, however, reporters will probably ask many questions and request further information. The education coordinator should be able to provide basic answers and to cite or distribute materials.

Reporters should also be invited to attend workshops or other discussions of elder abuse and neglect. During these sessions, information packets or press kits should be handed out. Kits should include:

A short description of the problem.
A few short anonymous case histories.
A description of the local problem.
An outline of proposed or actual response mechanisms.
Plans for mobilization such as a legislative initiative.

If a workshop or speech is to be given by an authority on the subject, the education coordinator should contact the press and local radio and television stations to arrange interviews. Local talk shows can be an effective means of diseminating information.

Local stations and newspapers also carry public announcements (PSAs) received from nonprofit groups. The coordinator should write a PSA to correspond to each lecture, workshop, or speech given on the problem of elder abuse, and also should send a press release to all media contacts whenever the group has something substantial to report. A typical PSA for TV or radio and an example of a press release are provided on the next two pages.

SAMPLE PUBLIC SERVICE ANNOUNCEMENT

20. Seconds, Public Service Announcement
Contact: Education Coordinator (123) 456–7890.

TO AIR JANUARY 2, 1981

Each day we get older. And as we approach old age, our need for love and affection increases. Yet research indicates that families under stress may abuse or neglect their older members. The Committee on Care for the Elderly is sponsoring a free lecture on how your family can support its older adult. It's tonight at Union High School, 7:30 p.m. Come and hear what you and the community can offer the older person. For more information, contact the committee at (123) 456–7890.

[Sample press release]

For Immediate Release: January 2, 1981
Press Contact: Jane Doe (123) 456–7890

The State Probate Court said today that it plans to implement a new Office of Court Investigators, which will be responsible for investigating complaints of abuse and neglect against elder citizens. The move is seen as a victory for the Committe on Care for the Elderly, which fought for a court-appointed authority to work with local law enforcement officials and care providers in the treatment and prevention of elderly abuse.

BIBLIOGRAPHY

Austin, M. J. A network of help for England's elderly. Social Work, 1976, 21, 114–119.

Block, M. R. and Sinnott, J. D. (eds.) The Battered Elder Syndrome. College Park, Maryland: University of Maryland Center on Aging, 1979.

Brody, E. M. The aging of the family. Annals of the American Academy of Political and Social Science, 1978, 438, 13–27.

Douglass, R. L., Hickey, T. and Noel, C. A Study of maltreatment of the elderly and other vulnerable adults. Ann Arbor, Michigan: Institute of Gerontology, University of Michigan, 1980.

English, R. W. Combating stigma toward physically disabled persons. In Robert P. Marinelli and Arthur E. Ell Orto (eds.), The psychological and social impact of physical disability. New York: Springer, 1977. Franklin Research Center. Elder Abuse. Philadelphia, Pennsylvania, 1980.

Gelles, R. Family Violence. Beverly Hills and London: Sage, 1979.

Koopman-Boyden, P. G. and Wells, F. The problems arising from supporting the elderly at home. New Zealand Medical Journal, 1979, 89, 265–268.

Lau, E. and Kosberg, J. Abuse of the elderly by informal care providers: Practice and research issues. Paper presented at the 31st Annual Meeting of the Gerontological Society, Dallas, Texas, November 20, 1978.

Legal Research and Services for the Elderly. O'Malley, Helen. Elder Abuse: A Review of the Literature. Boston, Massachusetts, 1972.

Legal Research and Services for the Elderly. Elder abuse in Massachusetts: A survey of professionals and paraprofessionals. Boston, Massachusetts: 1979.

Legal Research and Services for the Elderly. An analysis of the laws concerning elder abuse in Massachusetts and other states. Boston, Massachusetts: 1979.

Legal Research and Services for the Elderly. An analysis of protective service systems for handling elder abuse cases. Boston, Massachusetts: 1979.

Moroney, R. M. The Family and the State: Considerations for Social Policy. London and New York: Longman, 1976.

Regan, J. J. Intervention through adult protective services programs. Gerontologist, 1978, 18(3), 250–254.

Steinmetz, S. Battered Parents. Society, 1978, 15(15), 54–55.

Steinmetz, S. The use of force for resolving family conflict: The training ground for abuse. Family Coordinator, 1977, 26, 19–36.

Straus, M. A., Gelles, R. and Steinmetz, S. Behind Closed Doors: Violence in the American Family. Garden City, New York: Anchor/Doubleday, 1980.

Treas, J. Family support systems for the aged: some social and demographic considerations. Gerontologist, 1977, 17(6), 486–491.

APPENDIX 2

A Statement for the Record on Elder Abuse by Adult Caretakers: An Exploratory Study by Linda S. Boydston and James A. McNairn

Mr. Chairman, my research partner and I have recently completed a project entitled, "Elderly Abuse By Adult Caretakers: An Exploratory Study". The purpose of this study was to seek preliminary estimates of the prevalence of elderly abuse in San Diego, California. The focus was on elders over the age of 60 who reside at home and have been physically or psychologically abused by members of their families, or by friends or caretakers.

The information was collected through a survey of medical, legal, law enforcement and social service professionals who were chosen according to their interaction with the elder population and the likelihood that they might encounter the phenomenon of elder abuse. The survey questionnaire attempted to determine: 1) If there is a problem of significant proportions within the country, 2) locate professionals most likely to encounter cases of neglect and/or abuse, 3) distinguish characteristics of the maltreatment, and 4) identify current responses and interventions used by agencies in treating this problem.

Out of 431 questionnaires, distributed to a cross-section of human service providers, 101 were returned with 67 of these citing a case of elder abuse. Therefore, the fact that elder abuse does exist within San Diego County is confirmed. The results of this research are very similar to those of other major studies done in Massachusetts, Maryland, Michigan and Ohio. Significant findings are presented and are briefly discussed below.

1. Private social service agency workers, protective service workers, hospital social service workers and visiting nurses accounted for the majority reporting abuse citings.

2. Abused elders were reported to be the most often abused between the ages of 70 and 84 and women were more often reported to be abused than men, regardless of age. Ages 70–74 were reported in 25 percent of the citings, ages 80–84 in 19 percent and ages 65–69 and 75–79 in 18 percent of the citings. Of the 67 citings of abuse 73 percent were women and 27 percent were men.

3. Seventy-six percent of the citings indicated that some sort of physical abuse was inflicted on the elder. Reported injuries covered a wide range from physical bruises and welts, cuts and punctures, malnutrition, direct beatings and bone and skull fractures to neglect of personal care and lack of supervision. Sixty of the 67 surveys listed more than one type of abuse was observed. One person was reported to have died due to injuries sustained.

4. Eighty-five percent of the citings indicated that some sort of psychological abuse was inflicted on the elder. Types of psychological abuse ranged from moderate threats to the elder to severe verbal assaults which caused debilitating fear to situations of isolation and abandonment. Again, multiple psychological abuse was prevalent.

5. In seventy-six percent of the citings the abused elder had a mental or physical disability which restricted him or her in meeting daily needs. Physical impairments included being bedridden, needing assistance with personal hygiene, inability to prepare food and inability to take medications. The majority of respondents listed these as severe problems. Mental impairments were most often listed as moderate-severe to severe. Common evidence of mental impairments listed were: confusion, senility, organic brain disease, fear and anxiety, depression, poor memory and poor judgment and response.

6. Very significantly, incidents of abuse tended to be recurring events rather than single occurances. Seventy percent of the citings were reported to happen twice or more. Of these, 49 percent reported the abuse happened more than twice and 19 percent reported that it was continuous.

7. Family members, rather than strangers, were most frequently the abusers. Most often, abusers (79 percent) tended to live with the elder they abused. Adult sons accounted for 27 percent of the citings, daughters 19 percent, husbands 19 percent and wives 13 percent. There tends to be disagreement among the major studies in the area of the sex of the abuser, some reporting adult sons as most frequently the abuser and some reporting adult daughters. Clearly, more research is indicated. Nine percent listed two or more abusers. In these cases the abusers tended to be the elder's adult child and his or her spouse.

8. Seventy percent of the respondents regarded the elder as a source of stress to the abuser(s). Frequently mentioned reasons were the amount of physical and emotional care required and the high level of dependency placed on the abuser by the elder.

9. The survey data indicate that the majority of the abusers were experiencing some form of stress at the time the abusive act occurred. The leading stress provoking factors were medical complaints, financial problems and substance abuse. Lack of needed services was another category often cited by respondents as contributing to abuser stress. Over half (55 percent) stated that the abuser was experiencing two or more forms of stress simultaneously.

10. Most abuse cases surfaced as a result of personal observation by the respondents (28 percent) or self-report by the victim (27 percent). Sadly, the fewest referrals were made by police, family or friends.

11. A wide variety of interventions were described by respondents which included counseling, emergency medical care, removal from home and referral to various community agencies.

12. Seventy-five percent of all surveys indicated that some barrier to service provision was experienced by providers. Most often (43 percent), the victim was the barrier, refusing to acknowledge the abuse or allow corrective action to be taken. This obstacle to intervention was closely followed by the lack of cooperation from the abuser (42 percent). The family was cited as the barrier in 15 percent of the surveys and 13 percent indicated that a legal problem constituted a barrier to intervention.

Clearly, it can be seen that elder abuse is a problem and the fact that studies are turning up very similar findings in different parts of the country indicates that the problem is not localize, but widespread. This study, and others like it, is proof that the problem exists and that much needs to be done to adequately meet the needs of those involved. Social, legal and medical services must coordinate to meet these needs. The abused need to be supported and educated to the fact that they need not be embarrassed to admit the problem. The abusers need to know that they are coping with enormous stress and can go to an agency for help, rather than fearing punishment, as one legislator suggested they deserve. To start this process laws must be enforced which provide for protection during the revelation of an abuse problem and services which help both the abused and abusers. I believe Bill H.R. 769 is a very good first step in this process.

Thank you, Chairman Burton, for holding the hearing to explore these issues. I hope my information has been helpful.

DISTRICT ATTORNEY,
San Francisco, Calif.

As violent crime becomes an issue of great focus, the elderly victims of those crimes have come to receive more study and attention. However, despite the increased media exposure and programs to aid the elderly, older citizens continue to be vulnerable as victims of crime.

At the Victim Witness Assistance Program we encounter those older victims of crime. It is our goal to assist these victims in receiving compensation for their losses through the California State Board of Control. The state will reimburse for medical bills and wage loss. Many elderly victims have these losses covered by medical, medicare and receive social security and therefore are not eligible for compensation.

Upon talking to these individuals one finds they have incurred a great deal of economic hardship. If these victims are robbed in their homes, personal valuables that can never be replaced are lost, also a television or money may also be taken. If an individual receives about $400.00 a month, these losses can mean a great hardship. It would be desirable if victims could receive replacements for items that are replaceable, and funds could be made available for rent, food and transportation if so required. It would only be helpful to the victims if the assistance be made soon after the incident. Victims awaiting compensation now wait 6 months to a year under the Victims Crime Act in California.

Prevention of a violent crime is the most desirable course of action. Continuation of public safety awareness programs and safe, convenient transportation to prevent street crime are vital to crime prevention. Older citizens should be aware of the dangers that exist on city streets but this should not cause them to be unable to go out to take care of their everyday chores. If they do become victims, they should not be the ones that have to pay for those crimes by economic hardship. The Victim Witness Assistance Program urges those in government to assist in the prevention of crime as well as assist those who have become victims in a more concrete manner.

DON JACOBSON,
Chief Assistant District Attorney.

MARIN SENIOR DAY SERVICES,
Mill Valley, Calif., April 1, 1981.

Congressman JOHN BURTON,
Chairperson,
Subcommittee on Retirement Income and Employment.

DEAR CONGRESSMAN BURTON: Enclosed are materials which describe support services for families caring for disabled elders at home. These families are under a great deal of stress due to the constant, 24-hour care required for their disabled family member. Abuse often occurs in families under stress. Relief of this stress is essential to ease the burden of care and hopefully decrease abuse. Our program provides such support through day care, emotional support groups and home care. Community-based supportive services to caregiving families is necessary to help ease family stress and decrease abuse of elders.

CECILIA LONDON, M.S.W.,
Program Director.

WOMEN WHO CARE AND THE WIVES RESPITE PROJECT

Nursing Dynamics, a non-profit agency in Marin County, California, has been providing day care and support services to handicapped older adults and their families through its Marin Senior Day Services program. In September 1977, soon after the day care center opened, the Agency became the sponsor for a support group for women who were caring for their disabled husband at home, a predominant living arrangement among day care clients. The founder and organizer of the group, Women Who Care, is Clemmie Barry, an older women who cared for her own stroke-disabled husband for 16 years. In a letter she sent to prospective group members, Ms. Barry describes her motivation and intent for starting such a group.

My first motivation for this sharing came when I became aware of how many women die during this caretaking. I was shocked. . . . I have decided there must be a change: that we, the wives, can no longer be ignored.

I believe that one of the ways to begin to make the necessary changes could be for us to build support among ourselves as a group or on an individual basis, or both. I am willing to be the focal point for such an undertaking. I am a caring listener. Each of our experiences are as different as we are different individuals . . . .

. . . I would hope that we might create an atmosphere among ourselves where the unshed tears, the too long contained grief, and yes, even the anger and frustration might find an outlet. That confidentiality and safety of expression would be guaranteed. That no one would give advice, nor make judgments. Personal decisions and solutions must come out of each person's own understanding of her need.

WOMEN WHO CARE

Women Who Care meets twice a month in a trusting environment where the women's common problems of on-going caretaking can be shared. The group focuses on three main issues: emotional support, political activism, and education. One meeting a month is devoted exclusively to emotional support. During these meetings, the women share their feeling and sense of relief that someone finally understands. Some of the common concerns and problems expressed are: the fatigue from waking two and three times at night to take their husbands to the bathroom; the frustration from constantly changing urine-soaked sheets; isolation from friends who are uncomfortable around their chronically ill, disabled spouses; sadness over the loss of a husband who is so changed now; anger at the myth of the "Golden Years" that never materialized; guilt about the thoughts of placing their husbands in a nursing home as their own health deteriorates from the physical and emotional stresses of constant caretaking.

The political action meetings focus on advocacy and developing strategies to effect change in the current long term care system which has failed to provide adequate respite and support for these couples in the community. One of the specific issues addressed by the group is the Medi-Cal (Medicaid) regulation which requires that when a spouse is institutionalized, all of the couple's combined assets must be exhausted before Medi-Cal will assume the cost of nursing home care. The women are working to change this regulation so that assets can be separated at the time of placement, leaving the spouse in the community with a reasonable measure of dignity and financial security. Otherwise, both husband and wife end up impoverished, a prospect frightening to most women who can expect to live longer than their mates.

At the group's educational meetings, so far the women have heard from lawyers and Medi-Cal eligibility workers who have come to educate and offer expert advice. Many of the wives have been forced, by their circumstances, into assuming responsibility for financial management for which they have been ill-prepared.

Women Who Care is essentially a feminist group. After many years of traditional marriage roles, these women are taking control of their situations amidst a background of continual crises. They are forming ties of sisterhood and support with other women in the group and together they are working to seek changes in a health care system which has to date been unresponsive to their needs.

THE WIVES RESPITE PROJECT

The idea for this project originated with Women Who Care. Group members repeatedly stressed the need for more respite services such as day care and home care and the need for greater public awareness and recognition of the problems they experienced. Several group members met with agency staff to help draft the proposal for a project which could begin to address these needs and would serve as a model of service delivery.

The Wives Respite Project was funded in May 1979 through grants from the San Francisco and Van Loben Sels Foundations for a period of two years. The major services provided through the project are home care and out-of-home respite care free of charge. Home care is available for four to eight hours a week per couple. Two half-time registered nurses each visit 5–6 couples each week. The nurses' services cover a wide range, from companionship and supervision of the husband while the wife is away from home to assistance with the husband's personal care and doing errands that the wife is unable to do such as grocery shopping. The nurses also play an important role in health teaching and providing ongoing emotional support to both husband and wife.

The out-of-home respite service was designed to offer the wives an extended break from caretaking. Most of the women have not had a vacation away from their husbands in several years, mainly because there are no affordable, short-term facilities that could care for their husbands in the community.

The respite weekend, as it was called, was four days in duration and was held at a seminary conference center adjacent to the MSDS day care center. Round-the-clock care for the husbands was provided by staff from MSDS including nurses who were on duty from 4 p.m. to 7 a.m. From the viewpoint of the wives, husbands, and staff alike, this component of the project was a resounding success. The agency plans to continue to offer this service on a regular basis throughout the year.

To develop community awareness and recognition of the problems experienced by older women in these situations, the project also includes production of a videotape and a community workshop for primarily health care professionals. The videotape, titled "Women Who Care: Living with Disabled Husbands" focuses on one couple involved in the project, the problems they face, and demonstrates how the services have helped them. It is available for rental or purchase on either ¾" color cassette or ½" B/W reel-to-reel.

Marin Senior Day Services is providing a unique composite of supportive services to families of disabled elderly through its day care program, respite project and Women Who Care Support Group. Much of our focus has been addressed to the special needs of the wives caring for their disabled husbands at home. This high risk group of women who provide a much utilized source of care for the chronically ill has been a largely unrecognized group. Our program was responded to the needs of this population and demonstrated its effectiveness through its valued reputation in the community and the many grateful comments of the caretaking wives who thought that no one cared.

CALIFORNIA LEGISLATIVE COUNCIL FOR OLDER AMERICANS,
San Francisco, Calif., April 3, 1981.

My name is Rev. Edward L. Peet. I am president of the California Legislative Council for Older Americans.

Mr. Chairman our council hails this inquiry. It reflects the kind of kindly concern you have had all through your public life. It exposes dark areas of callousness and abuse of helpless elderly to public view. It shows a shocking record of human rights violations. But it also tells us of the tensions that prevail in relations between age and family groups in this upsetting turbulent era of American history. We salute this committee and its splendid concern.

Mr. Chairman, our council has been speaking up for elderly Californians for eleven years. We would be remiss now if we did not add another factor in this seamy equation. I speak of the widespread elderly abuse which is building up now from Washington. While the traumas you're talking about are private and hidden—the traumas I speak of are public and open for all to see. I speak of the threats openly proposed to social security benefits. I speak of billions to be cut from medical. I speak of the miseries now building up against two million American elderly in food stamps. I speak of brutal cuts intended to cut off homeless elderly from new and adequate housing. I speak of elderly abuse to those who cannot any longer pay their exorbitant fuel bills and who shiver in the dark. What of the abuse coming down from the young old who face the end of work because of being disabled by heart or arthritis ailments? What of these wholesale cuts against the old and the young that number in billions of dollars? So its bombs we want to build? But the Hungry oldster can't eat bombs: Nor can he heat his house with bombs: Nor can he be kept out of nursing homes with bombs: Nor can he anticipate any serene future in a county that steals his bread and gives him the scepter of a third world war.

We don't need elderly abuse wholesale or retail but we do need elderly care. Anything less mocks all our talk of a "land of the free and a home of the brave."

I thank you.

STATEMENT OF MAUREEN SATZ, STUDY DIRECTOR FOR RESEARCH ON ELDER ABUSE, UCLA/USC LONG TERM CARE GERONTOLOGY CENTER

Thank you for giving me the opportunity to testify at this hearing. I am Maureen Satz, and am representing the UCLA/USC Long Term Care Gerontology Center as Study Director for research on elder abuse. This research has been conducted with Elyse Salend, Deputy Director of the Long Term Care Gerontology Center, Dr. Rosalie Kane of the Rand Corporation, and Dr. Jon Pynoos, Director of the Institute for Policy and Program Development at the Andrus Gerontology Center, USC.

The Long Term Care Gerontology Center has recently completed a study analyzing the design and implementation of mandatory reporting legislation for adult abuse and protective services in sixteen states. Survey data was obtained from administrators of state Adult Protective Services department, State Departments of Aging, and supervisors of social service workers within these departments. Due to the recent societal recognition of the elder abuse problem, and the establishment of mechanisms to deal with it, the reporting statutes and protective services programs are currently in a process of evolution.

On the basis of research results, the Long Term Care Gerontology Center strongly supports the passage of HR 769, the federal legislation proposed by Representatives Oakar and Pepper and cosponsored by John Burton, for the identification, treatment and prevention of elder abuse, neglect and exploitation. This legislation is a necessary incentive for states to develop effective adult protective services legislation and programs.

Effectiveness in the area of protective services is a critical issue that has been unevenly addressed nationwide. Adult abuse reporting legislation developed from states' efforts to specifically address the needs of adults who are unable to care for themselves or protect themselves from abuse, neglect and exploitation. The laws provide extra societal protection to the elderly, a particularly vulnerable segment of our population. The purpose underlying mandatory reporting legislation is to identify cases of adult and elder maltreatment which would not otherwise be brought to public attention. Many of the reporting laws were modeled after child abuse reporting laws, which are now federally mandated.

Mandatory reporting statutes and adult protective services legislation were passed to provide the statutory authority for protecting incapacitated and maltreated adults. Prior to passage of this legislation, social service workers were providing protective services without statutory authorization. This situation involved potential risks for protective services workers, who often operated in a vulnerable legal position, and for clients, whose rights regarding societal intervention were not delineated in the law. In the area of protective services, the need for state intervention must be balanced against the individual's rights to self-determination. The adult protective services legislation attempts to establish clients' rights and the implementing department's authority in law, rather than leaving intervention to the discretion of the individual worker.

Mandatory reporting legislation provides the statutory basis for a protective services system and a mechanism for state intervention in protective services cases. The legislation requires reporting by professionals and others of suspected cases of adult maltreatment. It extends the statutory authority to social service departments for accepting reports, investigating cases, and providing services with the individual's consent or with appropriate court intervention.

The sixteen state survey conducted by the Long Term Care Gerontology Center indicates that the number of reports of elder abuse, neglect and exploitation has steadily increased since passage of these laws. Administrators of adult protective service units note that, due to the existence of reporting laws, their workers have been notified of life or death situations requiring immediate intervention—cases which would not otherwise have come to the attention of a service agency .

Based on preliminary data from the recent survey of states with reporting legislation, the following thirteen provisions have been identified as most important in the development of a model reporting statute and regulations attached to such a statute.

1. Designation of a State Agency to Implement the Law

The reporting statute should designate a single state agency responsible for receiving reports, investigating reports and implementing service plans. Ideally, the reporting mechanism would be a 7 day per week, 24 hour per day operation.

2. Contents of Report

A clear definition of what a report is to contain and how it is to be made should be contained in the statute. For example, a report should include identifying information regarding the persons involved, as well as the nature and extent of maltreatment. Mandating that an oral report be followed by a written one would aid in developing a uniform data system and might also serve to reduce the number of illegitimate complaints reported.

3. Mandatory Reporting

The statute should mandate reporting for any person who suspects that adult abuse, neglect or exploitation has occurred. Survey respondants indicate that without mandatory reporting, persons are unlikely to report situations of adult maltreatment. Several of the reporting statutes mandate only professionals to report. However, survey data indicate that the general public is in a position to bring to light cases of adult maltreatment which may never reach professionals. Often, cases of adult abuse or neglect do not reach medical or social service professionals until they have reached crisis proportions. Survey data indicates that reports are now being received from both the community and professionals. Knowing that the law required reporting can encourage action on the part of community residents who may otherwise be hesitant to get involved.

Broadening the group of mandated reporters would enable greater identification of cases in need of protective services. Such a step would follow the national trend in child abuse reporting legislation—that of broadening the group of mandated reporters, as well as the list of reportable conditions. Adequate public education, out-lining the public's reporting responsibilities and providing guidelines for reportable conditions, will ensure that more people in need of protective services can be identified and treated. As research indicates, the nature of adult and elder abuse is that it usually remains unreported and unaddressed.

4. Definition of Coverage

A clear definition of persons covered by the law should be included in the reporting statute. At present, variation exists in the definition of persons under the laws, purview, leading to difficulty in interpretation and implementation of the reporting statutes. The standard for coverage in the statute should include a functional inability to care for oneself of protect oneself from abuse, neglect or exploitation. Ideally, the reporting statutes should include all adults under its purview, rather than just the elderly. Inability to care for oneself or protect oneself from maltreatment is not necessarily a function of age, although the elderly are particularly vulnerable to such situations.

5. Immunity Provisions

Reporters acting in good faith should be guaranteed immunity from civil and/or criminal liability that might otherwise be incurred from making the report. Such immunity is a necessary protection for mandatory reporters, and serves to lessen the reluctance of the community to report a suspected case of maltreatment.

6. Confidentiality Provisions

Procedures should be established in the statute for maintaining the confidentiality of case records and protecting the identity of all persons involved. Such procedures would include well-defined protocols for expunging unfounded information, maintaining confidentiality of records, and authorizing access to case records.

7. Penalties

In the sixteen states surveyed, there was little or no prosecution of caretakers guilty of maltreatment. The recency of the statutes' passage, the difficulty of proving that abuse has occurred, the reluctance of victims to initiate criminal proceedings, and the need to develop good working relationships with the court system all contribute to the low prosecution rate. It should be recognized that, although penalties may be necessary in the law, criminal and civil remedies are not usually linked to the provision of social services and may not adequately address the needs of the abuse victim.

Sanctions for failure to report suspected maltreatment are included in certain reporting statutes at present, and have been recommended by survey respondents as a means of increasing the likelihood of abuse being reported. There has been little or no prosecution activities in this area also, although the potential benefit of sanctions or fines as a psychological spur to reporting has been noted.

8. Definition of Terms

The reporting statute should establish clear definitions of terms, such as abuse, neglect and exploitation. The statute should also define what constitutes a protective services case, an investigation, a substantiated case, and a successful case resolution. In order to identify abuse, neglect and exploitation, there is an obvious need to agree upon their definitions. At present, definition of such terms is not standardized among the reporting statutes, making it difficult to obtain a national data base on the extent and nature of adult maltreatment.

9. Central Registry

The reporting statute should include provisions for a central state registry that is maintained by a single state agency. The registry would include information on all reports received, investigation results, evaluations, and types of services delivered, including any court-related actions. Such a centralized client information system and standardized record-keeping are vital in determining the extent of the need for protective services and in building an accurate data base.

10. Emergency Intervention and Involuntary Service Protection

A reporting statute is of questionable effectiveness if it merely identifies cases, and does not specify any means for investigation and service provision.

A reporting statute should have the capacity for emergency interventions and long range interventions. This would include provisions for mandated investigations, specifying the nature of an investigation, and mandated time frames for investigation of reports.

In order to link enforcement mechanisms with the law, legal provisions for allowing access to a home in emergencies, and legal provisions for preventing interference from a caretaker in the provision of services may be necessary inclusions in a reporting statute or accompanying regulations which should clearly specify conditions requiring state intervention and procedures for case investigations. At present, many of the statutes lack well-defined procedures for intervention, hampering the implementing agency's ability to provide services.

In the establishment of legal interventions in the form of emergency services, protective placement, non-emergency services, and guardianship provisions, the need exists for flexible types of intervention. At present, some of the statutes only provide for the most severe type of interventions and do not tailor intervention strategies to the individuals need. This is particularly common in the area of guardianship provisions. Data from survey respondents indicates that legal remedies should be the last resort in protective services cases, and usually are not necessary if the case has been handled properly. The most successful protective service programs seem to be in those states were adequate outreach education, and networking with other agencies were performed in conjunction with passage of the reporting statute.

11. Due Process Safeguards

In establishing the legal authority to provide services, the reporting statute should specify that a person has the right to refuse services, unless he is judged incompetent. Involuntary services should be provided only in those cases where the individual lacks the capacity to consent to services, and is unable to care for or protect himself. Such involuntary services should be provided through appropriate court procedures, and lack of capacity to consent should be clearly defined in the law. Due process safeguards of the individual's civil and constitutional rights are clearly necessary in a law that sanctions state intervention in certain situations. The reporting statute should state that services provided should be those least restrictive of an individual's right to self-determination.

12. Geriatric Evaluation team

A model reporting law should contain provisions for comprehensive evaluations of clients to be performed before a placement decision or intervention decision is made. Such evaluations would be performed by a team of multi-disciplinary professionals, including medical, social service, mental health and legal representatives. An inter-disciplinary team approach may be necessary to adequately address complex problems.

Clearly defining the role of agencies involved in implementing the law has been recommended by survey respondents. This include establishment of a mechanism for compulsory law enforcement involvement in emergency situations where a worker must gain access to a home or remove a person from danger. In addition, it has been recommended that the role of medical involvement be clarified in the statute. Survey respondents note the difficulty of obtaining medical substantiation of cases of adult maltreatment. If the role of medical personnel was clearly mandated and defined in the law, accessibility of necessary medical services might improve, and the role of medical practitioners would be legally protected.

13. Funding Package

Some type of funding package should be linked to the reporting statute. Without funding to develop a protective service program, the law cannot be effective.

CONCLUSIONS

To conclude, survey results support the establishment of mandatory minimum standards to be legislated for states in the provision of protective services. The reporting statutes for adult and elder abuse are a potentially effective means of addressing the problem of adult abuse, neglect and exploitation. Data from the survey of states with reporting legislation indicate that service delivery to maltreated adults and elders has improved due to passage of these laws. However, as a piece of enabling legislation, a reporting staute cannot be effective unless it is tied to a total protective services package, with sufficient funding, enforcement mechanisms, and coordinated service delivery systems. The ability of an agency to respond adequately to reports is a critical factor in determining the law's effectiveness. Public and professional education concerning the law's requirements, inter-agency coordination, and documentation of cases are all necessary for the development of an effective protective services system.

Mandatory Reporting Legislation For Adult Abuse, March 1981

Elyse Salend, M.S.W., Deputy Director, UCLA/USC, Long Term Care Gerontology Center. Lecturer, UCLA, School of Medicine.
Maureen Satz, Study Director and Fellow, UCLA/USC, Long Term Care Gerontology Center.
Jon Pynoos, Ph.D., Director, USC Institute of Policy and Program Development, Fellow, UCLA/USC Long Term Care Gerontology Center.

This material has been prepared for the National Conference on Elder Abuse. A comprehensive report on the subject is currently being prepared. This research has been made possible by grants from the Administration on Aging and the Bureau of Health Manpower.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

The abuse, neglect and exploitation of the elderly has only recently been recognized as a problem that requires public policy and intervention. Effectiveness in the area of protective services is a critical issue, one that has been unevenly addressed nationwide. Most states have some type of protective services program that provides services to persons eighteen and over who are unable to provide for their own health, safety and welfare. The Senate Special Committee on Aging survey in March, 1980, identified 25 states which have some type of adult protective services legislation. However, the provisions and coverage of these laws vary widely in scope, as do the provisions of the reporting laws, a subset of the adult protective services legislation. The master chart included in this study identifies sixteen states with reporting legislation for adult or elder abuse and protective services. Other state statutes provide the mandate for a protective services system without reporting provisions. The majority of the sixteen reporting statutes were passed within the last five years, and similar legislation is now pending in several additional states.

The adoption of adult abuse reporting and protective services legislation developed from states' efforts to specifically address the needs of adults who cannot adequately care for themselves and/or protect themselves from abuse, neglect or exploitation. The impetus for passage of these laws arose from societal recognition that vulnerable, incapacitated and maltreated adults, particularly the elderly, were in need of extra societal protection, similar to that provided to abused and neglected children. The purpose underlying the legislation is identification of adult abuse, neglect, and exploitation cases which would not otherwise be brought to public attention. Many of the reporting statutes were modeled after child abuse reporting legislation, which is now a federal mandate. Although wide variation exists in the statutes' provisions, the common intent is to identify and protect incapacitated adults and elders who are victims of self-neglect or maltreatment by others. Variations in coverage of the statutes reflect the different impetuses and contexts which led to passage of the laws. For example, spouse abuse, abuse of the disabled, and abuse of care facility residents are covered in some of the statutes, but not in others.

Guardianship and civil commitment procedures have been the legal interventions commonly applied in cases of incapacitated or legally incompetent persons. Many states now have domestic violence legislation, directed mainly at spouse abuse, and establishing civil remedies and injunctive relief for victims of domestic violence. In addition, sanctions have been established in the Penal Code regarding abuse or injury to an individual of any age. The above remedies, however, do not specifically address the special problems arising in cases of elder abuse. Such cases typically involve a victim who is unable or unwilling to seek assistance or to initiate civil or criminal proceedings. The victim is frequently in a dependent position and frail, confused or ignorant of the societal protection mechanisms available. Weak enforcement mechanisms and the difficulty of prosecuting a case of elder maltreatment contribute to the inadequacy of these civil and criminal remedies in addressing the problem of elder abuse.

Basically, the legislation reviewed in this study requires certain persons to report suspected cases of abuse, neglect or exploitation to a central agency. Mandates for that agency to investigate and arrange voluntary and involuntary service provisions are included to varying degrees in the statutes. Procedures for provision of involuntary service to clients through court intervention also vary widely. The authority vested in the investigating agency, the criteria for emergency intervention and the protection of due process rights are not standardized among the statutes. Definitions of abuse, neglect and exploitation generally encompass the same components in the reporting statutes, although these categories overlap in certain statutes. The lack of uniform definitions, standards and procedures is a common problem of the reporting legislation as a whole. Vague or unclear definitions and stipulations are also common in the legislation.

The UCLA/USC Long Term Care Gerontology Center is currently completing a study of both the design and the implementation of the reporting legislation as it affects service delivery to abused, neglected and exploited elderly. Relevant to this purpose, the enforcement mechanisms, funding appropriations and social service delivery systems linked to the laws will be examined. The study will result in recommendations for improving current societal interventions addressing the problem of maltreatment of our nation's elderly.

Due to their recent development, statutes are in an evolutionary stage. Thus, the effectiveness of the reporting statutes cannot yet be fully documented. Many of the statutes have been amended since passage, as the implementators identify gaps in the design of the laws. Areas in which amendments have been added are useful indicators of the types of provisions necessary in an effective reporting statute. Such areas include confidentiality provisions, provisions for criminal penalties, and provisions for emergency service to clients.

Attempts to formulate a national policy addressing the issue of elder abuse are now underway. National legislation proposed in HR 7551 would provide financial assistance to states for prevention, identification and treatment of elder abuse, neglect and exploitation. Also proposed in this legislation is the establishment of a National Center on Adult Abuse for purposes of information compilation, research dissemination and technical assistance.

The following is a summary of provisions not included in the chart of laws:

Immunity

The reporting statutes guarantee reporters immunity from civil and/or criminal liability which might otherwise be incurred from participation in a report or judicial proceedings resulting from a report. Certain statutes specifically include in the immunity coverage representatives of the department responsible for receiving and investigating reports.

Report Contents

All of the reporting statutes specify that a report of abuse, neglect or exploitation include such identifying information as the names and addresses of the alleged victim and perpetrator, the nature and extent of maltreatment, and any other information relevant to the case. Some of the statutes specify an oral or written report by the reported; other statutes direct that an oral report be followed by a written one.

Confidentiality

The majority of the reporting statutes include provisions for protecting the confidentiality of reports and the identity of persons involved. In particular, statutes establishing a Central Registry specify procedures for maintaining the confidentiality of case records, expunging unfounded reports and authorizing access to records.

Privileged Information

Several of the reporting statutes stipulate that no common law or statutory privilege except the attorney/client privilege shall apply in judicial proceedings resulting from a case of abuse, neglect or exploitation. Privileges for confidential communications that are excluded in the statutes include husband/wife, physician/patient and clergy/client privileges.

Other Agency Involvements

Several of the statutes note the duty of other state, county and local agencies to cooperate with the department implementing the law. Certain statutes stipulate that the investigating department should report substantiated cases of abuse, neglect or exploitation to the State Attorney.

Least Restrictive Alternative

The majority of the reporting statutes state that protective services provided through the law should be the alternative least restrictive of the individual's self-determination and due process rights.

Geriatric Evaluation Team

A minority of the statutes provide for a comprehensive client evaluation to be performed at the point of involuntary placement or issuance of a protective service order. Where specified, the statutes direct such evaluations to be performed by a geriatric evaluation team composed of multi-disciplinary professionals.

Religious Provisions

Several reporting statutes affirm the individual's right to rely on nonmedical, spiritual means of healing in accordance with recognized religious methods, and exclude this criterion from being the sole determination of an individual's need for protective services.

NOTE.—Recent amendments to the laws may not be included in the chart.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
Alabama	Adult Protective Services Act of 1976.	18 and over, due to physical or mental impairment, cannot protect self from abuse, with no guardian or relative able and willing, whose behavior indicates he is mentally incompetent to care for self without serious consequences to self and others.	Not provided for in law.	Department of pensions and security.	County department of pensions and security or chief of police or county sheriff.	All physicians and other practitioners of healing arts.
Arkansas	Arkansas Statutes 59-1301—Act 166 of 1977, Adult Protective Services Act.	18 and over, persons suffering from developmental disabilities, the infirmities of aging or other like incapacities.	A statewide central registry to be established in department, and statewide toll-free telephone number for reports. (Registry includes treatment plan, case disposition.	Department of human services.	Department of human services.	Wide variety of professionals (doctors, nurses, hospital personnel, social workers, mental health professionals; peace officers, employees of public and private facilities); any other person may report.

State	Penalty for—		Payment provisions	Mandated time period for investigation of report	Case review mechanisms	Voluntary service provision
	Failure to report	Caretaker maltreatment				
Alabama	Guilty of misdemeanor; fine of $500 or less or 6 months or less.	Guilty of misdemeanor; fine of $500 or less or 6 months or less or both.	Department is not chargeable for the costs of care, except where such care is specifically provided for by law, or if department regulations and funding exist for such purposes. If person is eligible for service programs of department, follow usual department policies; if he is ineligible for department services other than protective services he is to make payment for services.	Agency receiving report must investigate within 3 days; law enforcement must forward reports received to county department of pensions and security within 24 hours.	After protective placement, department gives written report to court at least once every 6 months.	All protective services shall be in conformity with wishes of person to be served, unless the person is unable or unwilling to accept such services; in that case the court can order them. Department is re-required to provide services only for persons it is equipped to serve and agrees to serve.
Arkansas	Guilty of misdemeanor	Guilty of felony, lessor neglect guilty of misdemeanor.	No specific provisions	Receiving agency should forward report to central registry and to appropriate law enforcement agency; investigation must include home visit.	Department to make written report and case summary to State central registry. Reports into central registry should be sent to adult protective services immediately.	Protective services includes evaluation of need, arrangements for appropriate living quarters, securing medical and legal services, obtaining financial benefits. Any person may request voluntary protective placement, without relinquishing his civil rights.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Alabama	Not provided for in law	Not provided for in law	A guardian may be appointed by the court. Other than for the limited purpose of transporting for protective placement, the department should not be appointed guardian or custodian. If agreeable with person, court can appoint a guardian having the same powers as a guardian of a person of unsound mind (it is not necessary to hold sanity hearing). If adult needs protective services and is unable to manage estate, an interested person may petition the court to preserve the estate and direct use of it for person's needs.	If person does not consent or is incapable of consent, department can petition court for services; if it is urgently necessary to protect person's health, court may order protective placement. Any interested person may petition court for protective placement; court appoints hearing date within 30 days of petition filing; court appoints guardian ad litem if person has no counsel at hearing; court should follow individual preference for non-institutional care whenever possible.	Protective services should allow individual same rights as other citizens. Services should be designed to place least possible restriction on persons's liberty and constitutional rights, consistent with due process. In involuntary protective placement, court should give notice to others within 10 days of this action, on the person's location, etc. and set time for hearing on need for present placement; jury of 6 persons is impanelled to try the facts. Person cannot be committed to mental health facility under the act. No civil rights are relinquished as a result of protective placement; cannot give medical care if person objects on basis of conflict with religious beliefs. "As far as is compatible with mental and physical condition of adult, every reasonable effort should be made to assure no action's taken without full and informed consent of person."
Arkansas	Probate court can order entry into home.	Not provided for in law	No specific provisions	If there is imminent danger to adult's life or health, temporary protective custody can be arranged, not to exceed 72 hours; probate court and department shall be notified in order to initiate adult protective proceedings; certain persons or officials are authorized to take adult into temporary protective custody (police, person in charge of institution, agency employee can arrange it); if good cause shown probate court can issue order for temporary protective custody; person authorized in law to take person into custody may petition court to provide long-term protective custody.	If temporary protective order is used, hold hearing within 48 hours to establish probable cause for grounds for protective custody. Upon this finding, temporary protective custody can be ordered for up to 14 days, pending hearing for long-term protective custody. If long-term protective custody order is issued. Notice must be served on person at least 10 days prior to hearing. Court should decide according to least drastic alternative, including finding for noninstitutional care whenever possible. Person cannot be committed to mental asylum, unless in best interests. Court should review status of cases at least every every 6 months, from admission date. Person can appeal a long-term protective custody commitment.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
Connecticut	Public Act No. 77-613, Act Adopting a Reporting Law for Protection of the Elderly.	60 and over	Each regional ombudsman maintains a registry and forwards it to department on aging for statewide registry (includes reports, evaluations and recommendations).	Department of aging	Department of aging	Wide variety of professionals (doctors, nurses, employees of nursing homes, medical examiners, chiropractors, podiatrists, social workers, coroners, clergy, police, pharmacists); any other person may report; report within 5 calendar days.
Florida	Florida Statutes, ch. 827.09, Developmentally Disabled Abuse Act, passed 1973, amended July 1, 1980 to include elderly.	Disabled persons and those suffering from infirmities of aging.	In department of health and rehabilitation, modeled after child abuse registry (record investigation results).	Department of health and rehabilitation services.	Department of health and rehabilitative services.	Professionals and lay (doctors, nurses, psychologists, teachers, social workers, employees of private and public facilities).
	Florida Statutes S-409-3631 et seq., ch. 77-336, Adult Protective Services Act, passed 1977.	Individuals suffering from the infirmities of aging.	Not provided for in this law	Department of health and rehabilitative services.	Department of health and rehabilitative services.	Any person, including but not limited to, any social worker, physician, psychologist, nurse, teacher or adult care facility employee; shall report in accordance with Florida Statutes 5.827.09.

State	Penalty for—		Payment provisions	Mandated time period for investigation or report	Case review mechanisms	Voluntary service provision
	Failure to report	Caretaker maltreatement				
Connecticut	Fine of $500 or less	Not provided in law	If financially able, elder should pay for services. $50,000 appropriated to department of social services. Department on aging shall reimburse general fund for any amounts expended from funds appropriated to department of social services for act.	Prompt evaluation of report, including home visit (by regional ombudsman).	Department of social services reports treatment plan to regional ombudsman within 10 days of report receipt; after service authorization, department reevaluates case every 90 days.	If protective services deemed necessary, regional ombudsman refers case to department of social service for service provision, assuming client assents. If client does not consent or withdraws consent, services must stop, unless commissioner believes client lacks the capacity to consent, in which case he can seek court intervention.
Florida	Guilty of misdemeanor	Not provided for in law	Department authorized to make advances for program startup or to make periodic advance payments during fiscal year 1980-81.	Immediately	After determination of probable cause, department should notify appropriate human rights advocacy committee of alleged abuse.	Department has the right to authorize transfer of elder from nursing home.
	Not provided for in this law.	Guilty of felony if serious harm caused; guilty of misdemeanor if minor harm caused.	Department shall prepare a schedule of fees based on service cost and ability to pay, and may charge such fees to any client deemed able to pay.	No specific provisions in this law.	Department provide complete report to court if emergency services are rendered; department shall promulgate rules it deems necessary, re: protective services and temporary protective placement.	Department shall provide protective services: (1) if person in need requests them, (2) an interested person requests services for another, (3) Department determines person is in need of such service or (4) court orders such services. Protective services should be voluntary unless ordered by court, guardian, or provided in an emergency. Legislative intent to provide care for elderly in family type living arrangements in private homes as a alternative to institutional care; department to establish minimum standards for provision of such home care. Protective services shall include appointment of guardian or seeking protective placement, where appropriate.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Connecticut	Not provided for in law	Social service commissioner may petition court for order enjoining caretaker from interfering with service provision to which elder consents.	If person fails to consent to services, and regional ombudsman has reason to believe he lacks "capacity to consent," he refers case to department to determine whether to file petition to appoint conservator; probate court may appoint commissioner of social services department as conservator.	No specific provisions	If department petitions court to appoint conservator for elder lacking capacity to consent, elder can motion to review court's determination or any order issued pursuant to act; elder has the right to an attorney.
Florida	Not provided for in this law Upon probable cause, department representative, with law enforcement officer, may enter premises after obtaining court order; forcible entry without a court order can only be used in an emergency.	Not provided for in this law Not provided for in this law	Not provided for in this law No specific provisions in this law	Not provided for in this law Emergency services (court-ordered removal of elder from present surroundings) may be involuntary if a substantial risk of life threatening physcial harm or deterioration will otherwise be incurred. In this case, department, with court authorization, may take elder into custody or arrange for transfer to appropriate medical or protective facility. If such action is taken, hold preliminary hearing within 48 hours to establish probable cause for protective placement; upon such finding, court may order temporary placement up to 4 days, pending hearing for need of continuing services.	No specific provisions in this law. Services should place the least possible restriction on personal liberty and the exercise of constitutional rights consistent with due process and protection from abuse, neglect, and exploitation.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
Kentucky	KRS 209, Kentucky Adult Protection Act, passed 1976, amended 1978 and 1980.	18 and over (or married person without regard to age), who, due to mental or physical dysfunctioning, or, who is victim of spouse abuse, cannot manage own resources or protect self, and has no one willing to assist him.	Not provided for in law	Department of human resources.	Department of human resources.	Any person, including but no limited to law enforcement officer, nurse, social worker coroner, medical examiner, alternate care facility employee; death of adult does not relieve reporter of responsibility.
Minnesota	MSA 626.557 et seq., Reporting of Maltreatment of Vulnerable Adults, effective Jan. 1, 1981.	18 and over, vulnerable adults who, regardless or residence, are unable or unlikely to report abuse or neglect without assistance due to impaired physical or mental or emotional status.	Not provided for in law	State welfare department	Local police department, county sheriff, local welfare agency, or appropriate licensing agency.	Professionals caring for vulnerable adults (educators, law enforcement, employee in facilities); a person not required to report may voluntarily report if required reporter suspects direct or indirect death from abuse he should report to medical examiner or coroner, who does exam and reports to police and welfare departments.
Missouri	Senate bill No. 576, effective Jan. 1, 1981.	60 and over, unable to protect own interests or care for selves.	Department to maintain statewide toll-free number for receipt of reports.	Department of social services.	Department of social services, division of aging.	Any person.

State	Penalty for—		Payment provisions	Mandated time period for investigation of report	Case review mechanisms	Voluntary service provison
	Failure to report	Caretaker maltreatment				
Kentucky	Fine of $25–$200	Guilty of serious harm felony; causes minor injury; misdemeanor.	If need exists, department will provide services, within budgetary limitations; guardian ad litem fee, if appointed, to be paid by Department and not to exceed $300.	As soon as possible; appropriate law enforcement agency should also be notified.	Written report and recommendations; after emergency protective services provision, department reports to court once a month.	Intent is to authorize only the least possible restriction on exercise of personal and civil rights, consistent with need for services and person's safety and welfare.
Minnesota	Guilty of misdemeanor	Not provided for in law	$113,000 appropriated from general fund to commissioner of public welfare and is available to June 30, 1981.	Immediately; offer emergency and continuing protective services; upon receipt of report, police department should notify local welfare agency; welfare agency, upon receipt of report, should notify police and appropriate licensing agencies.	Agency should keep appropriate records.	If abuse occurred in licensed facility, welfare agency should immediately notify licensing agency of suspected abuse; licensing agency should investigate immediately, enter facilities; each facility should have abuse prevention plan (see appendix).
Missouri	Not provided for in law	Not provided for in law	No specific provisions	Prompt and thorough investigation by department of social services.	No specific provisions	Department provides social casework and counseling assistance in provision of services; services must stop if adult refuses or withdraws consent, unless director has reasonable cause to believe he lacks the capacity to consent, then he may seek court order; if adult consents to services, they should be arranged by department, in least restrictive environment available.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Kentucky	Search warrant may be issued if adult or care taker does not consent to investigation; any Departmental representative may enter licensed health facility.	Court may issue restraining order or other injunctive relief to prohibit any violation of chapter.	When court petition for emergency protective services is filed, court shall immediately appoint a guardian ad litem to represent adult, interview him and counsel on rights.	Court may order services on an emergency basis if adult lacks capacity to consent to services, it is an emergency, and he is abused; court may order protective services if person lacks capacity to consent or if he refuses and no one else is authorized to consent by law.	Intent is to require that due process be followed. After petition for emergency protective service is filed-issue summons and serve adult and cartaker with copy, at least 3 days prior to hearing. At hearing, adult may present evidence, cross-examine, petition to have order set aside.
Minnesota	Local welfare agencies have right to enter facilities and inspect records.	Not provided for in law.	No specific provisions.	When necessary to prevent further harm, agency shall seek authority to remove adult from caretakers; also determine if other adults are in jeopardy and offer protective services.	No specific provisions.
Missouri	Department can petition court for warrant to enter premises and investigate, if any person bars access to investigation by department.	Director may seek court order to enjoin person barring access from interfering with investigation.	If court finds an adult incompetent, it can appoint a guardian; if guardian refuses to consent to services, and person cannot consent due to incompetency or legal disability and danger of serious physical harm is likely, court can take such action as necessary.	If person lacks capacity to consent, and is in danger of serious physical harm, peace officer may transport adult to medical facility, he may also get court warrant to enter premises and remove adult; director of medical facility can get court order to treat adult.	Person cannot be committed to mental health facility under act.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
Nebraska	LB505, Child Protective Act of 1979, as amended in 1979 (First Protective Services Act passed in 1973, revised in 1978, but kept in Child Protective Services Act when that was amended in 1979).	Children, incompetent or disabled persons.	A Central register of child protection cases maintained by department; department of public welfare to file each report of suspected abuse or neglect in a a special State abused or neglected child, incompetent or disabled person registry; single statewide toll-free number within department (24 hours/day, 7 days/week).	Department of Public Welfare, or proper law enforcement agency.	Department of public welfare or law enforcement agency.	Any physician, medical institution, nurse, school employee, social worker, or any other person.
New Hampshire	State Law RSA 161-D, Protective Services to Adults, passed 1977.	18 and over, found to manifest a degree of incapacity by reason of limited mental or physical function which may result in harm or hazard to self or others, or who cannot manage own estate.	To be established at division of welfare (keep information on every case).	Division of welfare, department of health and welfare.	Division of welfare (if after working hours report to police department or county sheriff.)	All physicians and other practitioners of healing arts.

state	Penalty for—		Payment provisions	Mandate time period for investigation or report	Case review mechanisms	Voluntary service provision
	Failure to report	Caretaker maltreatement				
Nebraska	Or release of confidential information guilty of misdemeanor.	Not provided for in law	No specific provisions	Any reports received by department, also report to law enforcement agency; upon receipt of any report by law enforcement agency, it is duty to determine whether investigation deemed warranted; if so, to do it immediately—institute legal proceedings if appropriate; law enforcement to notify	Division shall make written report or case summary, as department may require, to proper law enforcement agency in the county and to the State registry of all reported cases.	No specific provisions.

				department if investigation undertaken (on next business day after receipt of report); division shall investigate each case referred by department, provide social services necessary to protect person and preserve family; law enforcement agencies receiving report to notify State central registry, next working day; division may request further help from law enforcement agency or take such legal action as appropriate.		
New Hampshire	Guilty of misdemeanor	Not provided for in law	No specific provisions	Director shall investigate within 72 hours of report receipt; law enforcement should notify department of health and welfare within 72 hours of report receipt.	No specific provisions	Protective services shall include guidance, counseling; when necessary, assistance in securing safe and sanitary living accomodations, and mental and physical examinations.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Nebraska	Not provided for in law	Not provided for in law	No specific provisions	No specific provisions	No specific provisions.
New Hampshire	Upon finding of probable cause, probate court can order police officer, probation officer or social worker to enter premises to investigate, if the adult or the caretaker refuses to allow Department representative to investigate.	Not provided for in law	If all other remedies are exhausted, director or authorized guardian may act to have guardian or conservator appointed by probate court, pursuant to RSA 464, for any adult in need of protective services.	No specific provisions	Protective services shall not include commitment to State hospital or school; probate court may order proposed ward to submit to medical or psychiatric exam, to be completed within 30 days, court gets written report. If proposed ward objects to the evaluation, probate court should be notified within 5 days after notification of evaluation's time and place, and hold hearing to consider objection before ordering evaluation.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
North Carolina	Protection of the Abused, Neglected or Exploited Disabled Adult Act, effective Nov. 1, 1974, amended 1976 to cover 18 and up.	18 and over, disabled adults or anyone physically or mentally incapacitated due to advanced age, conditions incurred at any age.	Not provided for in law	County department of social services.	Department of social services.	Any person with reason to believe.
Oklahoma	Title 43A of Oklahoma Statutes, sec. 801–810, Protective Services for the Elderly Act, passed 1977.	65 and over (amended from 70 and over effective Oct. 1, 1980.	Not provided for in law	Department of institutions, social and rehabilitative services.	Department of Institutions.	Any person.

State	Penalty for—		Payment provisions	Mandated time period for investigation of report	Case review mechanisms	Voluntary service provison
	Failure to report	Caretaker maltreatment				
North Carolina	Not provided for in law	Not provided for in law	Any funds for protective services system may be matched by State and Federal funds, to be utilized by county department of social services; if individual is financially able to pay, he should; if not, services are free.	Prompt and thorough investigation, including home visit, then written report.	Department should adopt standards within 90 days to implement act.	If adult consents, service provision can start; if he does not consent or withdraws consent, services must stop unless department determines individual lacks capacity to consent; it can then petition court to order services.
Oklahoma	Not provided for in law	Not provided for in law	Costs of protective services to be borne by department, unless person agrees to pay or department determines he can pay.	Prompt and thorough, diagnostic evaluation home visit, consultation with others.	No specific provisions	If person does not consent or withdraws consent, services stop, unless the department determines person lacks capacity to consent, then it can seek court authorization.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
North Carolina	Not provided for in law	Department can petition court for order enjoining caretaker interference; if need is there, person consents to services, and caretaker does not.	Court order may include appointing individual to be responsible for service provision; within 60 days of appointment, court reviews case to determine if petition should be initiated.	Department may petition court to order emergency services if the person lacks the capacity to consent, an emergency exists, person needs protective services, and no one else is able or willing to consent to service; emergency services may include physical custody; court shall hold hearing within 14 days of filing.	In petition for emergency intervention must give notice to person or spouse or guardian at least 24 hours prior to hearing on petition, unless court determines death or irreparable harm will result from delay. In emergency court order, only order services necessary to remove the emergency. Disabled adult must receive at least 5 days notice of hearing; has right to be present, to counsel (if indigent, State bears cost of counsel; court can appoint guardian ad litem if he lacks capacity to waive right to counsel).
Oklahoma	Department may petition court for entry into home; department representative should go with peace officer; in an emergency order, court may authorize forced entry to premises, to give services or transport elsewhere (peace officer accompanies department representative).	Department can petition court for order to enjoin caretaker interference.	In an emergency order, court appoints Department or a person as temporary guardian of the person, with responsibility to consent to services; if person still needs services after one renewal of temporary order, court can appoint guardian and/or apply for commitment to nursing home or other placement.	If person lacks capacity to consent, court may order involuntary services through emergency order; if adult is in substantial risk of death or immediate harm to self, lacks capacity to consent, and no consent can be obtained; emergency services may be provided for 72 hours, with 1 renewal for 72 hour period, upon proper showing; court can authorize continued Involuntary protective services for 6 months or less when the order for continued involuntary protective services expires, guardian or anyone else can petition court to extend order, not to exceed 6 months; emergency placement may be made to nursing home, foster care, but not to mental hospitals.	Anyone may petition to set aside court order. Protective services shall, to the maximum degree of flexibility, guarantee the individual the same rights as other citizens; give least restrictive services; court should only authorize least restrictive intervention, consistent with welfare and liberty, attempt to maintain person at home or in present living situation. In petition for emergency services, person must receive 48 hours notice of hearing, unless it is a situation of extreme danger; person has right to be present, to counsel.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
South Carolina....	Adult protective services law, protective services for developmentally disabled and senile persons, amended 1976 and 1979 (Act of 1082 of 1974).	18 and over, senile, developmentally disabled, mentally ill.	Not provided for in law.......	Department of social services.	County department of social services or sheriff or law enforcement.	All practitioners of the healing arts.

State	Penalty for—		Payment provisions	Mandate time period for investigation or report	Case review mechanisms	Voluntary service provision
	Failure to report	Caretaker maltreatment				
South Carolina....	Charged as accessory after fact and guilty of misdemeanor or upon conviction shall be fined not less than $100 nor more than $1,000 or be imprisoned for not more than 6 months; penalty for violating provisions of chapter, guilty of misdemeanor, and upon conviction fined $500 or less or 90 days in jail or less.	Unlawful to abuse, neglect, or exploit—guilty of misdemeanor upon conviction—fined not less than $500 nor more than $5,000, or be imprisoned for not less than 90 days nor more than 5 years.	Reasonable expenses for the evaluations required by chapter shall be borne by department, department shall seek appropriate Federal reimbursement for such evaluations.	Investigation within 3 days; reports by sheriff or law enforcement must be forwarded to county social service department within 24 hours.	Department which accepts a protective placement should make written evaluation and report at least once every 6 months on client's mental, physical, and social condition.	Protective services shall include arrangements for living quarters, obtaining financial benefits, securing medical and legal services; all protective services shall be voluntary unless ordered by the court or requested by a parent, guardian or friend; any interested person may request services on behalf of another.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
South Carolina....	Not provided for in law.......	Not provided for in law.......	In protective placement order, court shall appoint guardian ad litem for person. Before expiration of 90 day period, proper hearing shall be held to determine if further care is required.	Department, agency, or guardian can request family or other court to provide protective placement for care or custody of individual, it cannot be ordered unless court determines individual is unable to provide for	Protective services should allow person same rights as other citizens, while protecting from abuse, neglect, and exploitation; services should place the least possible restriction on personal liberty and the exercise of constitu-

own protection from abuse or neglect by another or by self; in protective placement, if court decides such agency care is urgently needed, department can assume custody, upon court order, and place person in facility for period not exceeding 90 days; use department resources to provide suitable permanent environment; with consent of person in custody, care period can go beyond 90 days; pending trial of any case, department is authorized to provide protective services; if conviction results, agency may continue such services till suitable permanent arrangements are made; court can provide such legal protection necessary to care for person; if person is unable to care for self due to physical, mental disability or financial resources, agency can immediately provide care to extent person is not taken into custody or removed from home or agency can petition court form temporary order authorizing agency to take custody and provide care till suitable permanent arrangements are made; prior to discharge from custody of department, department shall review need for continued protective service including appointment of guardian or limited guardian; court can appoint such a guardian, upon department's recommendations; at court hearing to get temporary custody order, any interested person can join or oppose the petition, but notice to such interested person is not required.

tional rights; court should follow least drastic alternative, including preference for noninstitutional care whenever possible; no civil rights relinquished when person requests voluntary protective placement.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters
Tennessee	Adult Protection Act passed 1978, amended 1980 (1980 amendment to 1978 law repealed the previous 1974 law) Protective Services for the Elderly (mandated protective services for 60 and up.)	18 and over, who because of physical or mental dysfunctioning or advanced age (60 or above) is unable to manage own resources, carry out daily living, or protect self from abuse without help from others and no one available to assist.	Not provided for in law	Department of human services.	Department of human services.	Any person including, but not limited to M.D., nurse, social worker, department personnel, coroner, alternate care facility employee or caretaker; death of adult does not relieve one of responsibility for reporting, however unless report indicates other adults are in similar situation and need protection, it shall not be necessary for Department to make investigation of circumstances regarding death provided proper law enforcement officials are notified.
Utah	HB No. 125, "Adult Protective Services", passed 1977.	18 and over, disabled adults who are incapacitated due to mental retardation, physical conditions, infirmities of aging or other like incapacities whose condition prevents them from providing for own care and protection.	Not provided for in law	Division of family services	Local police county sheriff	Any person, including but not limited to M.D., social worker, psychologist, nurse, teacher, employee of facility.

State	Penalty for— Failure to report	Penalty for— Caretaker maltreatment	Payment provisions	Mandated time period for investigation of report	Case review mechanisms	Voluntary service provision
Tennessee	Guilty of misdemeanor, fined not more than $50 or imprisoned not more than 3 months, or both.	Not provided for in law	If department determines protective services are necessary, it has authority to provide them within budgetary limitations and availability of unds, except where adult refuses services; if department determines adult can pay, adult shall reimburse State for cost of protective services; if not State bears cost; otherwise department can recover such cost from adult in any court; cost of administration of chapter and provision of shall be limited to amount of funds specifically appropriated for such purposes by general assembly.	Upon receipt of report department shall as soon as is practical: 1—notify appropriate law enforcement agency; 2—make an investigation of complaint; 3—written report of findings and recommendations; 4—notify reporter of its determination; 5—any department representative may enter any health facility licensed by State to carry out chapter's provisions; 6—any department representative may, with adult's consent, enter any private premises where alleged victim is to investigate. Investigation shall include a personal interview. Where abuse or neglect is allegedly cause of death, coroner's or M.D.'s report shall be examined as part of investigation.	Department may adopt such rules as are necessary.	Protective services can include investigation, procurement of suitable care in or out of home, legal determination of abuse, neglect or exploitation; if adult does not consent or withdraws consent to services, services shall be terminated, unless department determines he lacks capacity to consent, in which case it may seek court authorization to provide protective services; if adult elects to accept protective services, caretaker shall not interfere with provision of services; if, as result of investigation department determines adult who is resident of facility owned or operated by administrative department of State is in need of protective services, department shall make report of investigation, to commissioner with responsibility for facility, then it is responsibility of that commissioner and not department of human services to protect person.
Utah	Not provided for in law	Guilty of felony	Costs incurred to be borne by division of family services, unless court appoints guardian and costs are paid from the estate, or another government agency pays for eligible services.	No specific provisions	Division shall institute procedures to implement act, including guidelines for initiation of guardianship proceedings, referral to the public guardian, and designation of facilities for protective placement.	Intervention shall be consistent with the preferred life style of the adult; protective services should be voluntary, unless court ordered.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Tennessee	If adult or caretaker does not consent to investigation of private premises of alleged victim, search warrant may be issued upon showing of probable cause.	Any chancery court, upon proper application by department, may issue a temporary restraining order or other injunctive relief to prohibit any violation of this chapter, regardless of existence of any other remedy at law.	Any individual or organization appointed responsible for personal welfare of adult, has only specific authority granted in court order, to consent to specific protective services and appropriate custodial care if ordered; if adult needs person to manage his other affairs, appoint a limited guardian according to conservatorship law of 1980; department is not required to initiate proceedings for limited guardian or to assume such duties.	If department determines adult is in need of protective services, is in imminent danger of death, and lacks capacity to consent to services, then department may file complaint with court for order authorizing protective services necessary to prevent death; order may designate individual or organization to be responsible for welfare of adult; within 5 days of entering order, court should hold hearing on merits, if hearing is not held, order is dissolved; if department determines adult lacks capacity to consent and needs protective services, it can petition court for hearing; adult must get at least 10-day notice of hearing, has right to be present, to counsel; court order authorizing services may include designating person or organization responsible for welfare of adult; emergency protective services may include taking adult into physical custody in home or in medical or necessary to prevent imminent death; if court orders this, department shall review decree annually.	Adult must receive at least 48 hours notice of hearing on protective services; has right to be present, to be represented by counsel; State will bear cost of counsel if adult is indigent; no adult may be commited to mental institution or adjudicated incompetent under chapter; see provisions under Emergency Service Provision.
Utah	Not provided for in law	Division may petition court for decree enjoining caretaker from interferring with service provision, if the person consents or lacks capacity to consent to services, if he needs services, and the caretaker interferes.	Department may be appointed by court as trustee, receiver or guardian over person, estate, or both, pertinent to provisions of Utah Probate Code.	If disabled adult fails to consent to adult protective services, or if consent is withdrawn, or if the division determines the adult lacks the capacity to consent, division may petition court for authorization to provide protective services; if court finds adult lacks capacity to consent, and needs protective services, it issues order authorizing services by division.	Person given services has right to: hearing on the petition and its consequences (at least 10 days notice of hearing); to be present at the hearing or have interview by court, if physically unable; right to counsel, at every stage of protective services; if poor, court will appoint one; right to offer evidence on own behalf, to cross-examine witnesses; right to written statement of reason for protective order; right to least possible restriction on civil rights, consistent with adult's welfare and safety (after comprehensive assessment is made); any party may move for review of court decree at any time.

MANDATORY REPORTING LEGISLATION FOR ADULT ABUSE

State	Date passed	Persons covered	Central registry	Department responsible for implementation	Reports sent to—	Required reporters

Vermont	H282, elderly abuse reporting law, effective July 1, 1980.	60 and over	Health department should maintain registry, with written records of all investigations.	Department of health	Department of health	Any M.D., surgeon, osteopath chiropractor, or physician's assistant licensed or registered under title 26, any resident physician, intern, or any hospital nursing home or community care home administration, whether or not so registered, and any registered nurse, LPN, medical examiner, dentist or police officer shall report; any psychologist, mental health professional, social worker, clergyman or any other concerned person may report.
Virginia	Protective services for aged and infirm persons, passed 1974 amended 1976 and 1977.	18 and over, persons of advanced age, impaired health or physical disability who cannot care for selves, and persons 60 and over who are abused, neglected, and exploited.	Not provided for in law	State board of welfare and local boards of welfare.	Local departments of social services.	Doctors, practitioners of healing arts, social workers, mental health professionals, law enforcement officers.

State	Penalty for—		Payment provisions	Mandate time period for investigation of report	Case review mechanisms	Voluntary service provision
	Failure to report	Caretaker maltreatement				
Vermont	Violators of section shall be fined not more than $100.		No specific provisions	Health Department to investigate within 72 hours.	Health department has not yet developed procedures and protocol for investigating.	If need is determined, department offers services with a written treatment plan.
Virginia	Not provided for in law	Not provided for in law	Local departments should bear costs of service provision, unless client is financially able to pay.	Prompt investigation (including home visit and consultation with relevant others) by department of social services.	Written report by director, after investigation.	If adult withdraws or refuses consent, services must stop.

State	Provision to enter and investigate	Provision to enjoin caretaker from interfering	Provision for guardianship, conservatorship	Involuntary or emergency service provision	Due process safeguards
Vermont	Not provided for in law	Not provided for in law	Not provided for in law	Not provided for in law	No specific provisions.
Virginia	Not provided for in law	Director may petition court to enjoin interference with service provision.	If protective services still necessary after renewal of order for emergency services, court can appoint guardian; if adult lacks capacity to consent to receive protective services, they may be ordered through emergency order or through appointment of guardian—in so doing, court should authorize only intervention least restrictive of person's liberty.	Director of department may petition court for emergency order for protective services—if adult lacks capacity to consent to receive services, is incapacitated, and an emergency exists; emergency protective services can be provided up to 5 days, with 1 court renewal—temporary guardian will be appointed till expiration of order.	No person may be committed to a mental health facility under this section; elder shall be informed of hearing for emergency intervention, he has right to be present, to counsel; if he is indigent, hearing cost will be borne by State; elder has right to petition court to set aside emergency order.

[Many victims of elder abuse are physically and emotionally unable to testify personally at a public hearing. The following testimony was submitted for the hearing record on the behalf of victims of elder abuse who requested to remain anonymous:]

"HORTENSE"

This story does not begin with an eighty-year old woman being locked away on the high-security floor of a Rockville nursing home. It does not begin with a dozen people in a courtroom battling over the future of this woman and her possessions. Rather it is the story of two generations and begins at the time of her birth in the year 1900.

Hortense was born a twin, one of nine children of affluent parents in Marblehead, Mass. She was a shy girl, not very attractive, with a passive personality. The household was structured as were many households of that era: A strong dogmatic father whose word was law, a submissive mother who seldom opposed her spouse. Hortense grew up with servants in the household, and was automatically trained in knowing her place in life in relationship to theirs. She was given the best education, graduating with top honors from Smith. Her social life, however, was restricted because of her parents' control and because of her lack of confidence in herself and her physical appearance.

After graduation, Hortense worked her way up from file clerk to full-time secretary in a small manufacturing plant. One of her duties was to greet clients and customers. In due course, Hortense met George. Although fifteen years older, he obviously took a special interest in her. He questioned her about her family and background and determined that Hortense would make a suitable mate for him. Within two months, he asked Hortense's father for his daughter's hand in marriage.

Her father thought George was a highly intelligent man capable of making his way in the world and able to provide a good income for his "ugly duckling." Her mother thought George was an opportunist and felt that he was too old for her daughter. She voiced her disapproval—but her husband, of course, had the final vote. The marriage took place in 1926.

George was an astute businessman and had an excellent grasp of the economic situation. He sold his wife's stocks and placed her dowry in protected investments. When the Crash came in 1929, Hortense's father was ruined, but George's investments remained intact and the couple survived the depression years without hardship.

The following year their son, Bob was born. Hortense's pregnancy had been a perpetual embarrassment and the actual birth was an affront to her Victorian modesty and delicacy. To spare her any further humiliation, her husband had separate sleeping quarters installed in the house by the time Hortense returned from the hospital. Shortly afterward, George began a long career as an executive in private industry. He was ambitious, he worked long hours, and devoted himself to his career which flourished. Hortense was to maintain the home, handle the servants, and rear their son. Hortense worshipped George and allowed him to dominate her life, even to the amount of change she carried in her purse. The importance of their social status dictated that she have the freedom to spend as much as she wished, but she had to account for each penny daily.

During this era parents were being taught that babies would be spoiled by constant "mothering," and that a crying baby did not necessarily mean an unhappy baby. It was considered proper to ignore the baby's pleas. Hortense took this directive right to her heart. In later years, she recalled her emotional turmoil of listening to the cries of her son, but not daring to pick him up. She feared breaking the rules and being thought an unfit mother by her friends. After all, they all said they ignored their children and coped successfully, so why couldn't she?

Bob's life reflected the times and the social status as well as the upbringing of his parents. Meals at home were eaten with the servants. He was educated in private schools, and saw his parents on holidays. His mother had acquired a Rule Book of Life that allowed little deviation. She loved her son and provided him with the very best that money could buy. The only necessity missing from Bob's life was real affection. He rarely saw his father. George's accomplishments were paraded before him on every occasion and Bob was constantly reminded of his potential. At the same time he was taught that he could never live up the example set for him by his father.

Soon Bob was ready for college and entered Wesleyan. When it became apparent that he was going to be drafted, his father contrived to get him in the Air Force. When he was discharged from the service he went to work as a part-time mechanic in a local gas station. He was extremely capable and felt at home working with engines. His lack of cooperation with his parents' plans was a major disappointment. They insisted he complete his education and enrolled him at the University of Maryland. Bob felt out of place with the younger students and would not apply himself to his studies. His social life was practically non-existent. He seldom dated, knew very few girls, and was uncomfortable in their company. More and more time was spent with a group of friends hanging out in local bars. He dropped out of college and his father tried to interest him in entering the business world as his protegé. Bob refused.

Hortense could not understand her son's attitude toward her and George. She was genuinely puzzled over his refusal of any help but continued to apply pressure in subtle ways.

George died at the age of 75 in 1964. Hortense was 61. She was totally incapable of coping with her new status as a widow and heavily relied upon Bob to help her through this difficult period. When she was able to get him away from the bars long enough to stop by, he would do what was necessary to appease her. After a quick dinner, he would leave. It would be weeks before she would get him to return.

Bob married in 1965. The marriage lasted for ten years and produced two children. The relationship between his wife and his mother was one of constant conflict, perpetuated by Bob to gain control of both women. Neither was aware of his participation at the time.

When the marriage ended, Hortense was destined to remain in the background of her son's life. She rarely saw him and only by threatening to cut him out of her will would she actually get him to devote any time to her.

She was lonely and embittered. She missed her grandchildren dreadfully. She had no relationship with her daughter-in-law and could not get her son to bring the children to see her. Finally, she swallowed her pride and contacted Ruth, her daughter-in-law.

The two women became friends founded on mutual love and respect. Ruth took Hortense shopping, invited her to dinner with her grandchildren, included her in the family life she'd missed, and provided the love Hortense had been seeking.

At 77, Hortense was beginning to assess the situation with a modicum of understanding and vaguely realized the effect she's had on her son's life. She automatically assumed all the blame and shouldered the guilt. Her little boy was a disappointment. He would never be the man his father was, and although she still did not understand the why—she certainly knew the results. And she did not like what she saw. Her son was weak, contriving, and an alcoholic.

Hortense spent many hours by herself, as she had never been able to form deep relationships with anyone. Most of her friends were wives of her husband's business associates. She no longer had that life and was unable to adjust to another. She began to feel listless, tired and run down. Her doctor gave her very little attention. He was not a geriatric specialist and could not understand the particular problems of the aging. But she had been seeing him for sometime and was reluctant to make a change.

A retirement home was suggested for Hortense. She visited several and seemed to like the idea, but was still unsure of the best route to follow. Bob told her she would be able to take her possessions and set up a mini-apartment. The retirement home would provide the necessary care, but allow her the freedom to conduct her life with dignity and independence.

According to her son, the arrangements had been made and Hortense had signed the necessary papers to admit her to the retirement home. The big day arrived. Bob went to pick up his mother. She asked where they were going and he answered—for a drive.

Hortense sensed something was wrong and refused to leave her house. At this point he bodily picked her up and drove his mother to the home. He then left for an extended vacation out of the state and made himself unavailable to the retirement home.

Hortense was installed in a room in the basement that had all the warmth of a room at the YWCA. The next morning Hortense decided to leave. She got as far as the front door before she was escorted, none to gently, back to her room. Her doctor was called and he left orders for her to be tranquilized.

168

The retirement home staff was quite unhappy with this belligerent woman who was upsetting their calm routine. She had been placed in their care, obviously against her will. They were unable to contact her family and did not know the best way to proceed.

They asked their staff physician to see her. He found a highly agitated, but spirited woman, who was quite vexed at being denied her basic liberties. She emphatically told the doctor she wanted to return to her home. His hands were figuratively tied—as she already had an attending physician.

After spending several frustrating days at the home, Hortense managed to place a phone call to Ruth. When her daughter-in-law arrived, she found Hortense with no change of clothing, a toothbrush, a hairbrush, and nothing else in the room that Hortense was expected to occupy for the remainder of her life.

Ruth immediately provided Hortense with some of the needed articles, pictures, personal possessions, and television from her house, and had a phone hooked up for her use, much against the advice of the staff.

Ruth visited Hortense daily. She spoke to the management of the staff and determined that nothing could be done without her son's direct approval. On several occasions when Ruth was visiting, the nurses brought medication for Hortense to take. When she refused, they would insist. When Ruth questioned as to what the medication was, the nurses declined to answer, stating only that "it was necessary." Ruth wondered for whom.

After two weeks, Ruth and Hortense agreed that she would be more comfortable in her own home. Hortense agreed to engage a companion that would serve as a cook, nurse, chauffer and general housekeeper. Hortense had been living alone for some years and did not want to have to "feel responsible" for another person, but agreed in principle, the idea had merit. She had far too much free time, and she could also provide the room without rearranging her household.

Ruth moved Hortense into her household until suitable help could be found. It was during those few days that Ruth made an appointment for her mother-in-law to be seen by Hortense's regular physician. She had been through quite a bit lately, and wanted to ascertain first-hand knowledge of Hortense's physical status. Ruth also wanted to check the medication to see if it did indeed provide any practical benefit. The doctor was rude, abusive and treated Hortense in a manner far worse than common criminals receive when they entered a prison. He shouted at Hortense and requested her to leave his office.

The next day Ruth took Hortense's medication to the pharmacist and asked for a refill. The pharmacist questioned Ruth if the medication was for the same individual. When Ruth asked why, the pharmacist said that one medication was an "upper" and the other and "downer" and taken together would make a person so confused they would never know where they were."

Ruth decided to discontinue Hortense's medication. During the next few days, her mother-in-law responded in a startling change. Her facilities improved almost overnight. She was calm, cognizant of her situation, ameniable to suggestions, but more importantly, was aware of what her son might possibly be trying to attempt. She agreed to a companion and within a week moved back into her own home.

Hortense did suffer from insomia. She felt she needed company far more at night. Two women were hired, one from 8:00 a.m.–4:00 p.m., the other just the opposite shift. Although these were unusual hours, it was not difficult to provide. A routine was established—but unfortunately, it did not last.

Bob returned from his vacation. He was furious. He forcefully pushed his way through his mother's door, fired the nurses on the spot, and dragged his mother off to a psychiatrist. The doctor saw a woman whose agitated behavior he interpreted as confusion and loss of control. Bob returned his mother to her home shortly thereafter stating he wanted nothing further to do with her. She was obviously beyond help. He opened the car door and unceremoniously deposited his mother on her doorstep.

The next morning he returned and managed to convince Hortense he was actually sorry for his actions of the day before. He got her into his car and drove off to Sibley Hospital and had her committed to the psychiatric ward. She was locked in a high-security section that contained alcoholics, dope addicts, schizophrenics, uncontrollable neurotics as well as criminals. She was sedated. Two days later, the psychiatrist had her moved to the less restricted area of the ward. In the meantime, Bob had made arrangements for her to be admitted to a nursing home in Rockville. The hospital provided transportation and Hortense was driven in a van to the nursing home about a week later.

Hortense had suffered horrible indignities by this time. She appeared in a daze and repeatedly asked when she would return home. Ruth found her mother-in-law about a week later. Disoriented, she'd lost weight, was disheveled, and in a state of extreme depression. She cried in the younger woman's arms and pleaded to go home. There was little Ruth could do except provide Hortense with the necessities of life and visit with her. Ruth became a "regular" at the Nursing Home and quickly endeared herself to the staff.

One morning about two or three weeks after, a woman called Ruth at home with an unusual request. She identified herself as a "liason" on the nursing staff. She asked Ruth if it would be possible to remove her mother-in-law from the home. She stated that Hortense was in full possession of her faculties, was not senile, and did not belong in a nursing home environment. If Ruth did not remove her mother-in-law, the "liason" felt that Hortense would die within a few weeks due to the excessive medication being given to her. Although adamant in her beliefs, the woman requested to be anonomous, and stated she would deny every part of their conversation.

Ruth called a friend of Hortense's for help. Within hours an attorney was reached, documents drawn and Hortense walked out the front door of the nursing home on the arm of her new attorney. Thirty minutes later, she was back home. The attorney quickly arranged for help in the house, but the next days had to be the most difficult that Hortense had to live through in her entire life.

She was immediately withdrawn from her medication. This produced a semi-zombie state, but within twenty-four hours, she had begun to respond to a more normal human being. Two days later, Bob returned and again forcefully dragged his mother back to the nursing home. This time instructions were given for her strict surveillance.

Somehow Hortense managed to avoid swallowing her medication. She was confused, heartbroken, depressed, but still maintained enough spirit to be fighting mad. It is not known how she managed to evade the ever watchful eyes of the staff, but within twenty-four hours, she managed to escape by walking out the front door onto the busy intersection of Route 28 and 70S. It is also not known how she managed to "flag" a taxi, but she did. She convinced the driver to return her to her home in Chevy Chase. Bob had removed her purse, her money, and her house keys . . . but somehow this spirited 78 years old woman managed to get home, pay the cab driver and enter her own home. That night she slept peacefully in her own bed.

By the next morning, Bob discovered her whereabouts and once again had his mother incarcerated. This time, the medication was administered with a much more watchful eye.

Ruth tried in vain to help. Hortense's attorney used every avenue available to him under the law. But Bob held all the cards. After all, he was her only relative . . . He secured an attorney and within days a date was set in Court to have the case decided before a judge on just who would be Hortense's guardian, both her purse and her person.

The morning of the trial arrived. All the interested parties sat in court waiting for the case to be heard. A nurse attended Hortense. She was completely tranquilized. She appeared not to understand where she was, and knew little about what was happening. Finally, it was Hortense's hour. The Judge asked if she had someone to represent her. Both attorneys responded. A document was introduced into evidence stating that Hortense had fired her first attorney. Not only had it been forged, but it was the first admission on Bob's part that another attorney had entered the picture. The Judge decided to ignore that and asked Bob to bring his mother and his attorney to his chambers. Ten minutes later they reappeared. Hortense's attorney had the opportunity to question the other lawyer. He stated that the Judge had given Bob legal guardianship over his mother's person and her finances. She was returned to the nursing home and remains there today.

She is kept in a sedated state, has lost between twenty and thirty pounds, is usually filthy, has no conception of time or where she is and remains in a child-like state. She is probably not too uncomfortable. She does not know what has happened. Occasionally she speaks of going home, but for the most part appears to be one of "those batty old women" locked away from society for their own good.

The nursing home is divided into two sections. The first floor is given to patients who are mobile and are cognizant. The second floor is reserved for patients confined to beds and those who are considered uncontrollable except with strait jackets and/or excessive medication.

The law states that any individual may be committed to an institution if two doctors state that a person can be judged homicidal, suicidal or to have a recognizable psychiatric disorder. These laws are loosely interpreted.

Certainly Hortense's life as a dominated child and dominated wife allowed this treatment and furthered her inability to protect herself. Certainly Bob's life with a domineering father perpetuated the actions necessary to produce the misplaced hatred for his father into his mother.

Certainly, we cannot legislate moralities nor can we hope to make society responsible for all overt actions.

But aren't we responsible for laws that would protect the Hortenses' of the world? Cannot we legally intervene if we see such flagrant abuses of another's rights?

I certainly hope so, for Hortense's sake, and for all the others that are abused in their declining years—for whatever reasons.

I live in the section of San Francisco known as the "Tenderloin," consisting of cheap hotels, run-down saloons, massage parlors, porno shops, lower-priced tourist hotels, sprinkled with a few marginally priced ones, and hotels for senior citizens, some of them dirty dumps. There are five senior citizen hotels within a two-block area. Many of the senior citizens residing in the Tenderloin are handicapped, using four-legged walkers, canes, crutches, and wheel chairs to get around. These people are routinely mugged in this area, in broad daylight, some stopped on the street by thieves who simply rifle their victims' pockets while pinning their arms. I myself have been robbed a couple times like this. Many seniors won't go out their front doors at night, and they restrict their day-time outings to essential trips. I still leave my hotel room when I choose, to attend meetings, go to the grocery store, and the like, because these assaults are not limited to the dark hours.

Our attackers know our patterns; so, you would think, should the police, who could give us special attention in our areas, from Leavenworth to Mason, along Eddy Street, by cruising the neighborhoods around the first of the month when we get our checks. Thugs almost stick out their palms, waiting for payment like our bill collectors. I suppose when the finer hotels finish building in the area and a few tourists get mugged and assaulted (maybe even when one is killed), police department budgets will reflect the need for increased surveillance.

At my senior citizen hotel, I was mugged at 9:00 in the morning. I was expecting a phone call, so I cracked open my door when someone knocked. The fellow put his face up to the door, asking for someone who didn't live in the building. I tried to close the door, but he pushed his way in, telling me he had a revolver. For a fleeting moment, I thought to push the alarm button that's on the wall in each of the rooms, which would let the desk clerk downstairs know something was wrong. I decided against it, figuring it would only aggravate my attacker if he saw me do it. He himself rang the bell; I told him it was a broken light switch. I later found out the damn thing didn't work anyway. My attacker was very professional in his search, punching me in the chest to knock me out of his way. He looked through my clothes in the closet, my dresser drawers, and under my mattress. When he was ready to leave, he hog-tied me with an extension cord, tying my arms and legs behind my back.

I finally managed to free myself, since no one heard the struggle or were too frightened to do anything. The night clerk called the police when I went downstairs, and they took my statement, deciding not to take me to the hospital since I was only bruised from the cord. I felt violated because of this experience, although I later considered myself fortunate when I learned my attacker had killed one of his victims.

I have suffered psychologically from this attack. I have no recourse, other than through the civil courts, and then I have been advised that court action would be unprofitable for the attorney and myself, even though I can prove the hotel is responsible for letting this animal into the building when the poorly trained, low-paid clerk did not bother to question the fictitious name and room number (the thug had the gall to sign the register with a non-existent room number) my attacker used, and I can prove the alarm bell was not in working condition.

Soon it will be the first of the month again. The retired elderly might have a bit of extra money in their pockets. The thieves and muggers will be out in full force near and around senior citizen housing. That's a fact.

APPENDIX 3

A SUMMARY OF

ELDER ABUSE

(AN EXAMINATION OF A HIDDEN PROBLEM)

A Report by the House Select Committee on Aging

INTRODUCTION

Since the beginning of time, no law has been etched in the mind of man with the force of the command: Honor Thy Father and Thy Mother. It is also true, as the historian Toynbee observed, there is a positive correlation between care and respect of the elderly and the greatness of a civilization. Novelist and social critic Simone de Beauvoir expanded upon this observation in *The Coming of Age*, when she noted, "The manner in which a society behaves with its older people unequivocally reveals the truth . . . of its principles and its ends."

Among the Ancient Greeks, for example, the best thing that could be done to win the favor of the Gods and the respect of fellow citizens was to care for one's father and mother in their old age. Under the laws of Solon, a legitimate son who failed to care for his parents upon trial and conviction lost that item most precious to any Greek: his citizenship. Striking a parent, refusal to maintain an indigent parent or the neglect of the duty of burial were all high crimes punishable by stiff prison penalties.

In modern America just as in Ancient Greece, respect and veneration of one's parents is still the expected norm. Most Americans do respect and honor their parents although there are disquieting signs of erosion of this great moral value.

From time to time there have been stories in the public press about children who have neglected their parents. There have also been occasional references to individuals who purposely assault or abuse their loved ones. From the increasing volume of such stories and from the growing numbers of letters the Committee receives on the subject, the House Select Committee on Aging perceived that the number of these incidents had been rapidly increasing over the past five years.

Chairman Claude Pepper asked the Committee staff to begin to examine the problem. Preliminary investigations confirmed earlier suspicions. Chairman Pepper scheduled a series of hearings by the House Select Committee on Aging to further test this premise and directed the staff to conduct an in-depth investigation. This report is the result of that effort.

This report is the first intensive national investigation ever undertaken of the topic which has come to be known as "Elder Abuse." It explores a shameful and hidden problem which has tremendous and far-reaching consequences for all Americans.

Section I of this report describes the nature of elder abuse and provides numerous shocking examples of physical, financial, psychological and sexual abuse of the elderly by their family members.

Section II attempts to measure the dimension of the problem based on evidence collected from many quarters concluding that the problem of elder abuse is not only widespread but that the incidence of such abuse is increasing dramatically.

Section III explores the current theories as to why the problem exists. Section IV explores the experiences of the States with respect to the problem and Section V examines the efforts of the States to deal with the problem, concluding that few of them have given the problem the attention that it deserves.

Section VI explores the Federal interest in this issue and suggests ways in which the Federal government can help the States in their efforts.

Section VII summarizes this report's primary conclusion that the incidence of physical, financial, psychological and even sexual abuse of the elderly exists in America in dimensions that few have realized; that the incidence of such familial violence and abuse is escalating rapidly; and that apparently a parallel can be drawn from child abuse where a measurable increase in abuse can be found in hard economic times.

Lastly, Section VIII provides the Congress and the States with a number of policy options which might be adopted to deal with this pervasive problem.

It is hoped that this report will lead not only to additional discussion and research on this important question but also to a heightened awareness on the part of the media and the public to a problem which has too long been swept under the rug of complacency. It is also hoped this report will result in legislative reforms at both the State and Federal levels.

I. THE NATURE OF ELDER ABUSE: CASE HISTORIES

The notion that many sons and daughters are purposely and repeatedly abusing their parents is something which is alien to the American spirit. Most people in the United States would be skeptical that the practice exists on anything but an extremely limited scale. Over the past few years, however, there have been an increasing number of studies within the academic community which suggest that the problem is far more important and widespread than has been realized to date.

It was these reports and studies which caused the House Select Committee on Aging to begin holding hearings on the subject of elder abuse. Elder abuse is defined simply as the physical, sexual, psychological or financial abuse of the elderly or otherwise causing the deprivation of their human rights by their relatives or caretakers.

Early hearings by the Committee were for the purpose of exploring the parameters of the problem on the assumption that it would not be proven to be a problem worthy of the attention of the Congress. It was assumed that to the extent that there was a problem, it would be handled by the States. This assumption was wrong.

The Committee hearings quickly served to reinforce the findings of academicians who had concluded elder abuse was a hidden and growing problem. Evidence was received which indicated elder abuse was a matter of growing social importance and that most of the States have not acted to protect the best interests of the elderly. Indeed, in the face of the assertion that elder abuse cases may be equal in size and scope with child abuse cases, the States continue, with rare exceptions, to concentrate their funds almost exclusively to deal with child abuse. Moreover, it is obvious that there is a void in State statutes with respect to protections and services for the abused elderly.

This section of the report makes difficult reading. Hundreds of examples are provided from the Committee files. As noted, the examples are meant to be illustrative, not exhaustive. These shocking examples of the abuse of the elderly by their loved ones are current and virtually all the States are represented. The States which have given the matter of elder abuse the most attention are overrepresented in these examples. State officials predicted to the Committee that as they begin to devote more of their resources to the problem they will undoubtedly uncover hundreds and thousands of additional examples.

The examples which are set forth in this section are entered because there is no other way to prove the depth and scope of this serious problem. The Committee does not mean to suggest in this report that the States should cut back on their protection to children; rather, it is suggested that they increase their protection to adults.

Each example below is a classic in the history of man's inhumanity to man. The fact that the perpetrators are most often tied to the abused by blood makes the example all the more horrible. Some of these abuses which take place in the privacy of the homes of the elderly rival or exceed abuses which have come to the public eye from nursing homes. Indeed, as will be seen below, nursing homes frequently provide the refuge for battered and abused family members. This is not to excuse abuses in nursing homes which still exist on too great a scale but it is enlightening to learn that nursing home owners and operators are not always the culprits in this very real human melodrama.

What follows are examples of elderly individuals who have been abused physically and sexually by their relatives. There are examples of where they have been neglected and their rights abrogated. Finally, there are examples of financial and psychological abuse and a few cases of self-abuse which were brought on or exacerbated by family members. These cases are illustrative of the wide range of incidents which have been termed "elder abuse" by different States. As of yet, there is no consistency with which States define such abuse except for in all cases, the perpetrator is a family member or caregiver and that harm results. Most cases should include a pattern or practice of abuse over time rather than limited to one isolated abusive incident.

It should be clear beyond any doubt following the reading of this chapter that the problem needs attention. The examples for the most part come from questionnaires the Committee sent to police chiefs, protective service workers, visiting nurse associations as well as from Committee hearings and correspondence received by individual members of the Committee.

A. Physical Abuse

Physical abuse is conduct or violence which results in bodily harm or hurt, excluding mental distress, fright, or emotional disturbance. The Committee reviewed many reports of older persons sustaining physical injuries from their sons, daughters, other relatives and caregivers, ranging from grabbing an arm forcefully and painfully, to exasperated shaking or shoving, both potentially dangerous to an older person, to repeated physical and sexual attacks and beatings. Physical abuse on the part of the older person's family and caregivers can lead to dire consequences:

—A 92-year-old Massachusetts woman was admitted to a hospital emergency room severely beaten, severely bruised, and with a skull fracture. She died a week later. A son and daughter-in-law, with whom the bedridden woman lived, are considered suspects in her death.

—A Massachusetts grandmother's death resulted when her grandson allegedly shot her then apparently burned the house down to cover up the crime. It was only when the medical examiner examined the victim that the gunshot wound was discovered. The case is being prosecuted under a criminal indictment. It was later learned that the grandmother had been physically assaulted by her grandson on several occasions in past years.

—Caseworkers in Ohio investigated reports of mistreatment of an 86-year-old woman who lived with her son. The son protested that he had given his mother "wonderful" care, that he fed her daily, brushed her hair and bathed her. The woman was found living in filthy conditions. It was learned that the son had left the victim naked in bed all day and because of malnourishment, she had lost considerable weight. She weighed only 80 pounds when discovered by caseworkers. The sister of the victim who alerted authorities was unwilling to press charges. The woman died a month later.

—An elderly District of Columbia person who lived with a daughter-in-law, was often found with bruises on her face and head, ostensibly from falls. The older person was not given medication and was sometimes found dehydrated. She was sent to the hospital where death occurred.

—Another District of Columbia woman 80-year-old was found beaten to death and her acting caregiver was charged with the homicide. Detectives said the motive was robbery.

—A complete bed care patient in D.C. was murdered, by the son-in-law, an alcoholic who was left with total care of the patient when his wife was admitted to the hospital with mental problems.

—The North Carolina County Department of Social Services reported finding a 91-year-old widow lying on her bed. She had multiple severe bruises on her face, hands, arms and chest. She was incoherent and very confused. She was assessed to have been beaten approximately a week before. The daughter of the elderly woman had been beaten by her own son, also, and that was why she had not reported her own mother's condition. The elderly woman was transported to an emergency room where she eventually died. Her grandson is being held on charges of murder.

A number State Human Service Departments provided dramatic examples of sexual abuse of their elderly residents:

—A 69-year old woman from Iowa in day care complained of abdominal pain and vaginal bleeding. She revealed she had been raped by her brother-in-law, with whom she and her husband had been living after being evicted from their home. After reporting the problem, she filed charges against her brother-in-law who was jailed and is awaiting trial.

—Iowa also reported that an arthritic, slightly obese but otherwise healthy woman lived with her daughter and 22-year-old grandson who reportedly physically and sexually abused her. The daughter admitted there was familial conflict and wanted her mother to move. The mother was turning over $300 of her $320 monthly Social Security check to the daughter.

—In the District of Columbia, an 80-year-old woman, a paraplegic, had been sexually abused over a 6-year period by her son-in-law, who beat her with a hammer when she refused his advances.

—New Jersey reported that an hispanic lady of about 74 was assaulted physically and sexually by her son-in-law. The daughter was fully aware of the ongoing situation, and warned her mother not to say anything for if she did she would be made homeless. Neighbors and relatives reported the case for protective services.

—In an Ohio nursing home, aide reported that a 96-year-old patient was raped by another aide.

Many of the cases of physical abuse reviewed by the Committee were committed by those with alcohol and drug-related problems:

—An 83-year-old D.C. woman was forced to live with her alcoholic, brain damaged daughter, who neglected and physically and verbally attacked her.

—A bedridden elderly man from the District was brutally beaten by his grandson when he reportedly was under the influence of alcohol.

—An alcoholic caregiver in D.C. beat his elderly client, leaving the patient lying in urine on wrinkled bed linen.

—A 90-year-old bedridden D.C. patient lived with her alcoholic daughter and son-in-law in an unsafe apartment with no door lock. The patient, when found, was covered with bedsores and multiple facial wounds.

—A 78-year-old wealthy D.C. woman was beaten with a phone receiver by her 17-year-old adopted son. She declined to press charges or to sign a petition for a protective order. The son continues to live with her, receiving a large allowance and driving fancy sport cars. He is suspected of taking drugs.

Aside from discovering that many of the abusers who physically assault older relatives have alcohol-related problems, the Committee further discovered that many of the abusers suffer from mental disorders. For example:

—Missouri reported that a 71-year-old white woman lived with her 36-year-old son and 39-year-old daughter, both of whom were retarded. There was documentation of several minor physical attacks by the son. The third attack was major and required that the mother be hospitalized because of her critical condition. She remained in the hospital for four weeks and was then transferred to a foster home placement. Her absence from the household led to the eventual institutionalization of these two adult children.

Although the majority of the physical assault cases reviewed by the Committee involve abusive behavior on the part of immediate family members, we found that caregivers were, at times, also responsible for such attacks. For example:

—An elderly New York patient was forced to eat leftovers by her caregiver, was covered with bruises and sores all over her body as a result of repeated beating by the caregiver, and finally was forced into a hospital.

—An elderly woman from New Hampshire was brought to a hospital emergency room by her caregiver boyfriend. She had a fractured shoulder, had been punched in the face and knocked unconscious, and her upper ribs were black and blue. The house where the patient, caregiver boyfriend and a second male lived was filthy and alcohol bottles were scattered throughout the residence.

—New Jersey reported that an elderly man was assaulted physically by a boarding home operator, receiving injury that resulted in an occluded femoral artery.

—New Jersey also reported the case of a mentally retarded elderly client who would be seen from time to time in church sufficiently bruised and battered to raise suspicious questions about the care he was receiving in a boarding home. It was found that the abuse was perpetrated by someone in the home.

—A 70-year-old woman from the District of Columbia was found to be routinely victimized, physically and mentally, by her maid who would tie her with wire to the bed, leave her alone for periods of time and deny her the use of

> personal items. The older woman was obviously nervous and unable to talk in the presence of the maid. At an appropriate time, she revealed that the maid did tie her to the bed as a punishment for misbehaving, and that she signed over her checks to the maid. She had been forced to turn over to the maid approximately $5,000 in the previous few months. The maid also removed the phone from her room to prevent her from communicating with the outside world. The older woman was forced to give the maid her car and pay towing charges on it. When she did not comply readily, she would be pushed from her wheelchair. She was terrified because she had been pushed in such a manner that twice she suffered a broken hip and once a broken clavicle. Nursing home placement was also threatened. Eventually, the maid was indicted on extortion, false imprisonment, first degree grand theft and misrepresenting a licensed nurse.

It is the perceived threat of repeated beating, denial of daily requirements, and sexual assaults which occasionally lead some older people to fight back in self-defense. Such was the situation encountered by an elderly father in the District of Columbia who was charged with involuntary manslaughter after his son died during a scuffle with him. The elderly man said he just couldn't stand the son beating him up anymore.

B. NEGLIGENCE

Negligence can be defined as conduct which is careless; it is the breach of a duty which results in injury to a person or in a violation of rights. There is ample evidence of negligence by relatives and caretakers with devastating consequences to the helpless elderly. This section of this report details a few of these examples collected by the Committee from across the country. These abuses took place within the past few years. The list below is meant to be illustrative rather than comprehensive.

—In South Carolina, a 79-year-old woman who was recuperating from a stroke was kept in an unheated porch attached to her daughter's $90,000 house. The family refused to buy soft foods and to otherwise accept responsibility for the victim who became dehydrated and required hospitalization.

—In the same State, a 68-year-old woman living with her daughter was found by a caseworker in conditions of unspeakable squalor. The woman was kept in an unheated portion of the house where the temperature was measured at less than 20 degrees. When found, the woman had eight soiled blankets piled over her head to keep her warm and the urine from her catheter was frozen. She was also found to be malnourished. She developed pneumonia and was hospitalized. Under discharge, authorities had her placed in a nursing home.

—Washington State reported that they were alerted by concerned neighbors who noticed social security checks being delivered monthly and yet they had not seen a woman they knew as "granny" for over a year. Caseworkers arrived at the home where the woman lived with her daughter and grandsons but could not approach the home because of vicious dogs. They returned with the police and representatives of the humane society. The elderly woman was found locked in an upstairs room, dirty, disheveled, incontinent and malnourished. The victim requested that she be relocated to a nursing home.

—An elderly woman in New Jersey living with her daughter and son-in-law was systemmatically neglected. She was left at home all day without food. At night her potty chair and walker were removed so that she could not get up and go to the bathroom. Her personal correspondence was withheld and her telephone calls intercepted. One day the woman fell and was left alone to lie for about eight hours on the floor with a broken hip. When interviewed, the daughter said that she wanted her mother dead so that there would be no more problems. The woman was placed in a nursing home by authorities.

—An elderly paraplegic Arkansas woman had been hospitalized three times for surgery. Her husband refused to place her in a nursing home because he wanted continued access to his wife's Federal Supplementary Security Income check. The man was an alcoholic and used the proceeds to support his habit. It was learned by investigators that during the day he would load his wife into the back of his pickup truck and leave her there while he would go to drink beer at a local poolhall. During the women's subsequent fourth hospital stay, the husband died in a fire which broke out in the couple's house trailer. The woman was then placed in a long-term care facility.

—In Washington, an 84-year-old woman, terminally ill with cancer, was refused proper medical attention by her grandson who did not want the woman's property and income dissipated by doctor and hospital payments. The woman was found in tremendous pain, living in truly wretched conditions. The victim was transferred to a nursing home where she died a few weeks later.

—Caseworkers in West Virginia were alerted that an 80-year-old couple might be having problems. Upon investigation they found the husband ill to the point of being comatose. The man was described as "unable to respond, barely breathing with eyes glazed." The wife was exhausted and distraught from trying to care for her husband to the point where her mental condition was unstable. The wife would not allow authorities to remove the man to a hospital for treatment. She charged them with engaging in a plot to take her husband away from her. Caseworkers contacted the couple's daughter to assist them in persuading the wife that the man needed attention. They were unsuccessful and the husband died two days thereafter.

C. FINANCIAL EXPLOITATION

Financial exploitation involves the theft or conversion or money or anything of value belonging to the elderly by their relatives or caretakers. Sometimes, this theft or misappropriation is accomplished by force—sometimes at gun point. In other cases, it is accomplished by stealth through deceit, misrepresentation and fraud. In most instances, the loss of property by the elderly is immediate but in a few instances involving undue influence in the writing of wills, greedy family members have been willing to wait a few months or even years to acquire the property of a loved one.

In its inquiry, the Committee developed literally thousands of examples which fall into the category of financial exploitation. As is noted from other parts of this report, financial abuse usually is accompanied by physical and psychological abuse. The examples provided below are merely illustrative of the problem. They range from armed robbery of the elderly by their loved ones to larceny of their personal possessions to exotic schemes to defraud them of literally anything of value.

One of the most heartbreaking series of examples involves the elderly who lived independently until an injury or illness necessitated a stay in the hospital. Upon discharge from the hospital, many older Americans have learned to their chagrin that their families have literally sold their homes out from under them. Equally heartbreaking are those family members who have their loved ones committed to a public institution as a means of obtaining their property.

It became apparent to the Committee that to some extent, Federal policy under Medicare/Medicaid and the Supplementary Security Income program encourage the financial exploitation of the elderly. Generally, the exploitation revolves around the decision to place an older person in a nursing home or related institution. Since Medicare pays for only about 2 percent of the nation's total $17 billion nursing home bill, the elderly must pay these expenses themselves or look to their families. With average charges in American nursing homes running in excess of $12,000 a year and given the fact that no insurance can be found which will pay more than a modest amount of this bill, more and more families have been looking for ways to qualify their loved ones for Medicaid, the welfare nursing home program which is available without limit to the poor. Families have learned that if the elderly divest themselves of their resources and income, they will become eligible for Medicaid.

Many family members rationalize that it is a pity to waste money (even if it belongs to the elderly) on old people near death and that it is somehow compounding the problem to give this money to what they call greedy nursing home owners. For this reason, family members have taken money or property belonging to the elderly and then represented to State Medicaid workers with a straight face that the senior has no property, thus qualifying for Medicaid.

With respect to SSI—a program of cash grants to the poor elderly from the Federal government, the problem is caused by a provision in the law which reduces SSI payments by one-third if the senior lives with related individuals. There is also a provision which bars the receipt of SSI funds for most individuals housed in public institutions. What this means is that more and more old people are being entered in the Federal SSI rolls instead of being taken care of at home. The fact that public institutions are generally unavailable means the elderly are increasingly being placed in private for profit boarding homes. While the subject of boarding homes was incidental to this study, the Committee could not help but be moved at the tremendous number of abuses which were reported in boarding homes. While the matter merits further study, it would appear that boarding homes have replaced nursing homes as the premier havens for institutionalized abuse of the elderly in America. Indeed, a number of victims of boarding home abuse and of abuse at home by loved ones have found nursing homes a pleasant change by comparison. Examples of financial exploitation of the elderly follow:

—In Arizona, an 88-year-old bedridden, mentally incompetent woman who was being cared for by a young relative was placed in the cheapest available boarding home. Her stay at the home was paid for with the woman's social security check of $300 a month. Thereafter, the young relative began to spend the victim's $20,000 life savings. When caseworkers investigated, the victim was found suffering from bedsores and dehydration. In fact, the woman was so dehydrated according to official reports, that her lips were stuck together. Employees of the boarding home would not give the woman fluids because they didn't want her wetting the bedsheets. After an investigation, the victim was removed to a nursing home where she received proper nursing and medical care.

—In the same State, a woman who had worked for over 30 years and who enjoyed a liberal pension, suffered two broken hips at the age of 88. An acquaintance arranged for her to be placed in an unlicensed boarding home. Within two weeks, the owners had either forged the victim's name to checks or had her forced to sign over $2,300 in checks to them. The investigation revealed that the woman was purposely overmedicated in order to keep her in a stupor. The woman had numerous stocks and bonds which apparently had been misappropriated. Social workers hired an attorney to institute legal proceedings to recover funds inappropriately taken and moved the victim to a licensed nursing home where she is reportedly receiving excellent care.

—Also in Arizona, an 84-year-old World War I veteran with a diagnosis of congestive heart failure came under the influence of a "friend" who obtained the old man's power of attorney and opened joint bank accounts with him. The "friend" represented that the man had no relatives. Investigators learned of the case when the man was brought to the emergency room of a local hospital. The old man was malnourished, dehydrated and maggots had infested under his skin. Investigators learned that approximately $20,000 had been taken. Relatives were located in Florida and Michigan but they refused to accept responsibility for the man so a guardian was appointed by the court to revoke the power of attorney and recover the man's assets. Both the old man and State social workers were physically threatened but ultimately they were successful in recovering an automobile and much of the other financial assets. The man was placed in a county nursing home.

—California officials report that an 87-year-old widow in frail health and generally confined to a wheelchair, unable to care for her day-to-day needs, was allegedly the victim of physical and financial abuse from 1974 through 1980. A nurse companion who was also her conservator and three children depleted her financial resources by more than $300,000 while depriving the woman of proper medical attention, food or clothing. Caseworkers helped the woman to institute legal proceedings.

—In Atlanta a man in his sixties and his wife were financially abused by their 23-year-old son who stole from them and broke into their house when locked out after he had refused to work or leave the home. When the police refused to arrest him on three different occasions, and the warrant officer said he could not help the family, the father shot the son in the leg the next two times he broke in.

—A 77-year-old woman in Atlanta was abused verbally by her 23-year-old grandson whom she was supporting from a small fixed income. On occasions, he would steal her money.

D. PSYCHOLOGICAL ABUSE

In addition to being abused physically and financially, the elderly can also suffer emotional or psychological abuse at the hands of their relatives. At one end of the spectrum, psychological abuse includes simple name calling and verbal assaults. At the other end, it is a protracted and systematic effort to dehumanize the elderly, sometimes with the goal of driving a person to insanity or suicide. There are few things more pernicious in life than the constant threat by caretakers to throw the elderly into the street or have them committed to mental institutions. The most common weapon used in this warfare is the threat of nursing home placement. This kind of activity is associated more with concentration camps than with private homes where the elderly reside, however, several examples of these almost unspeakable offenses have come to the attention of the Committee. By its very nature, psychological abuse usually exists in combination with one or more other abuses. Following are some examples:

—In Massachusetts, a daughter-in-law harbored great resentment of her mother-in-law for whose care she was responsible. The daughter-in-law refused to contribute to the woman's support. The daughter-in-law converted her mother's-in-law social security check to her own use—often to buy alcohol. Over a long period of time, the elderly woman was verbally abused, threatened, and in fact, the daughter-in-law did periodically beat the woman. When this matter came to the attention of the police, they discovered that the daughter-in-law put the woman's food on the floor, telling her she was an animal and that she would be required to eat like one.

—A report from Delaware tells of a daughter-in-law who would keep her husband's widowed mother confined to the basement without social contacts. Anytime the widow tried to leave this captivity, she was verbally assaulted. After the widow broke her arm in a fall, the daughter-in-law added physical force, severely twisting the woman's broken arm on several occasions.

—An 87-year-old woman in Massachusetts was psychologically abused by her middle-aged son. On a visit to her on a day when she was not feeling well, he proceeded to discuss what monies she had, what insurance, and what brothers or sisters of his were to get her property in the event of her death. The conversation disturbed her greatly and the day after the discussion she went to bed, and never got out of it. One month later, she was dead.

—In California, an 87-year-old woman in ill-health, confined to a wheelchair, and unable to care for her daily needs, was repeatedly and systematically abused by her family and nurse companion. The mental and physical torture lasted six years. During this time, the woman was threatened, held prisoner, deprived of all contact with the outside world, not permitted to see friends and family, and battered.

E. VIOLATION OF RIGHTS

All Americans, whether young or old, rich or poor, well or sick, are invested with certain inalienable rights by the United States Constitution. In addition, further rights are conferred by Federal statutes and the interpretation of them (and the Constitution) by Federal Courts. In addition, there are other rights which have been granted to citizens by the respective States through their legislatures and preserved through their courts.

This section of this report sets forth only a few of those enumerated rights along with examples of how these rights have been breached or vitiated by family members who are placed in the position of providing care and assistance to their elders.

1. The Right to Personal Liberty.—The right to move freely, the right not to be imprisoned in one's home, the right to be free from physical restraints, are at the very essence of American democracy. However, there have been numerous examples in the preceeding pages of older Americans being held captive against their will, virtual prisoners in their own homes. There have also been numerous cases of individuals who have been restrained with ropes and wire; tied to their bed as well as locked in their rooms or homes:

> . . . A 19-year-old Illinois woman confessed to torturing her 81-year-old father and chaining him to a toilet for 7 days. She also hit him with a hammer when he was asleep. After she made him weak enough, she chained his legs together . . .

2. The Right to Adequate Appropriate Medical Treatment.—The right to prompt quality medical care and the right to some participation in medical decisions are no less basic to Americans. The preceeding pages, however, provide numerous examples where the elderly have been deprived of medical care by relatives who did not want to deplete the senior's assets, spend money of their own or lose the use of the senior's income. The case histories throughout this section confirm the hypothesis that a great number of America's seniors are not receiving the medical care they need. For example:

> . . . In Washington, an 84-year-old woman terminally ill with cancer was refused proper medical attention by her grandson who did not want the woman's property and income dissipated by doctor and hospital payments. The woman was found in tremendous pain living in truly wretched conditions. The victim was transferred to a nursing home where she died a few weeks later . . .

3. The Right Not to Have One's Property Taken without Due Process of Law.—The preceeding pages are replete with examples of relatives who have taken the property of the elderly and converted it to their own use. Sometimes this has been accomplished by force or through the use of weapons, in other instances, it has been accomplished by stealth through deceit and fraud. As the subsection on financial abuse indicates, the elderly are all too often easy victims of schemes to deprive them of their property. For example:

> . . . New Jersey officials reported a case where title to a woman's home had been turned over to her son, an attorney, apparently without the woman's knowledge or permission. Caseworkers were unsuccessful in their efforts to restore title of the home because of the unavailability of legal assistance . . .

4. The Right to Freedom of Assembly, Speech and Religion.—These protections specifically enumerated in the Bill of Rights have also been abridged and vitiated. Older Americans in many instances have been prevented from communicating with neighbors or friends. They have been prevented from having others in their home. In several instances, they have been denied access to the telephone and not allowed to receive mail unopened. In a number of cases reported heretofore, the elderly have been afraid to speak in front of their caretakers. No specific cases were received relating to breaching the right to practice religion, however, it is likely that this right has been abridged by some relatives of some senior citizens somewhere in America. The following is an example of an abrogation of this particular right:

> . . . In California, an 87-year-old woman in ill-health, confined to a wheelchair and unable to care for her daily needs was repeatedly and systematically abused by her family and nurse companion. The mental and physical torture lasted six years. During this time, the woman was threatened, held prisoner, deprived of all contact with the outside world, not permitted to see friends and family, and battered. Her nurse-companion (conservator) and three children with the knowledge of the victim's bank and attorney, depleted her assets by $292,000 as well as 200 shares of Caterpillar Tractor stock.

5. The Right to Freedom from Forced Labor.—The United States Supreme Court has upheld this right and yet many older Americans, as can be seen from the following example, have been forced to work to support indolent sons and daughters who collect the paychecks received by many of the elderly.

> . . . Caseworkers in Maryland told the Committee about a 67-year-old widow who was regularly beaten by her 35-year-old son. The widow was forced to turn all her property and assets over to the son who stopped working. When the income and money from property had been exhausted, the two subsisted on her $80 a month social security check. The widow did some babysitting to supplement this income.

6. The Right to Freedom from Sexual Abuse.—As noted from the preceeding examples, some seniors are not free from sexual abuse by their relatives and in-laws. In some cases, such abuse is carried out by force, sometimes enforced through the use of weapons. For example:

> . . . In the District of Columbia, an 80-year-old woman, a paraplegic, had been sexually abused over a 6-year period by her son-in-law, who beat her with a hammer when she refused his advances . . .

7. The Right to Freedom from Verbal Abuse.—Many senior citizens are being verbally abused on a daily basis by their relatives. The seniors often feel that they have little choice but to put up with such abuse. They believe that they are powerless to stop it and should they try, it would mean that care or food would be denied to them or that they would be forced out into the street or into a nursing home. For example:

> . . . In Michigan, a 70-year-old man was reportedly threatened by his 28-year-old son. The son was alleged to have a drug dependency problem and converted his father's social security checks to supply his habit. The father admitted he was intimidated by and lived in fear of his son. Social services workers helped the reluctant father initiate eviction proceedings against the son. During this process, the father had to be relocated temporarily in other living accommodations for his own protection.

8. The Right to Privacy.—The U.S. Constitution and related laws recognize a right of all citizens to a certain sphere of privacy. Unfortunately, as can be seen from the examples in the preceeding pages, privacy is very often denied to the elderly by their relatives. Quite often the denial of privacy is used as a weapon in the psychological war against the elderly carried out by their caretakers. For example:

> . . . A woman in Missouri, age 77, who had suffered a recent stroke and was bedridden was left in the care of her only son who was in his early 40's and on welfare. The son was a diabetic and suffered from asthma. The two people lived in a rowhouse confining themselves to the top floor bedrooms, cooking on a hot plate, and washing dishes in the bathtub. Since the son had 20 to 30 cats, the house was extremely filthy and filled with cat feces. Atlhough many agencies tried to intervene, the occupants would permit no one to clean the house. The son was married about four or five years although he intimated that the marriage was never consummated. The daughter-in-law who had since remarried still visited her mother-in-law. The son owned two or three motorcycles and had an extensive gun collection plus a room full of World War II mementos. Occasionally, he worked as a drummer in a nightclub and was frequently known to become drunk and violent. He had often beaten his mother who would contact the police when he did so. The police, aware of the problem, were often able to calm the son. At other times, he threatened to kill her and stated he wished she were dead. Although she was frequently ill and required constant health care, health aides sent to the house were threatened by physical violence by the son and were afraid to return. . . .

9. The Right to a Clean, Safe Living Environment.—This right is another which is frequently breached with far ranging consequences to the elderly. One result from the lack of clean living conditions can be illness, and another can be death. The following example is a violation of this right:

> . . . In South Carolina, a 68-year-old woman living with her daughter was found by a caseworker in conditions of unspeakable squalor. The woman was kept in an unheated portion of the house where the temperature was measured at less than 20 degrees. When found, the woman had eight soiled blankets piled over her head to keep her warm and the urine from her catheter was frozen. She was also found to be malnourished. She developed pneumonia and was hospitalized. Upon discharge, authorities had her placed in a nursing home.

10. The Right Not to be Declared Incompetent and Committed to a Mental Institution Without Due Process of Law.—State laws which allow family members to commit their elderly relatives vary widely. In some States, it is a fairly easy matter to effect such commitment, in others it is more difficult. As noted, some elderly people are adjudged incompetent upon affidavits from family members who have their own motives, usually related to obtaining possession of the financial resources of the aged person. For example:

> A 74-year-old Florida woman claims to have been taken to a mental hospital in the middle of the night, committed without the examination of two doctors. Her daughter and a psychiatrist she claims never examined or questioned her, signed commitment papers. Her home was then sold. She states her hospital papers diagnose her as having chronic brain syndrome and her attorney has termed her incompetent.

11. The Right to Complain and Seek Redress of Grievances.—The case histories in this section show that oftentimes seniors are not allowed to complain or to seek redress of their grievances from other agencies. Attempts to do so have been met with threats of violence or with reprisals of all kinds, including further loss of rights and privileges. For example:

. . . An anonymous caller reported to the Michigan Department of Human Services that a 65-year-old woman was being beaten by her children with whom she lived. On the first visit, the woman denied the beatings, since the children were in the home at the time. On subsequent visits, however, when the children were absent, she freely admitted to the beatings and wanted help.

12. The Right to Vote and Exercise All the Rights of Citizens.—As can be seen from the cases in this section, these rights are not always protected. Senior Americans, under the domination of their younger relatives and caretakers, all too often find they are on the outside of the American participatory democracy. For example:

. . . Washington State reported that they were alerted by concerned neighbors who noticed social security checks being delivered monthly and yet they had not seen a woman they knew as "granny" for over a year. Caseworkers arrived at the home where the woman lived with her daughter and grandsons but could not approach the home because of vicious dogs. They returned with the police and representatives of the humane society. The elderly woman was found locked in an upstairs room, dirty, disheveled, incontinent, and malnourished. The victim requested that she be relocated to a nursing home.

13. The Right to be Treated with Courtesy, Dignity and Respect.—It goes without saying from all the above that far too many elderly are not being protected in this basic right. For example:

. . . In Massachusetts, a daughter-in-law harbored great resentment of her mother-in-law for whose care she was responsible. The daughter-in-law refused to contribute to the woman's support. The daughter-in-law converted her mother-in-law's social security check to her own use, often to buy alcohol. Over a long period of time, the elderly woman was verbally abused, threatened, and in fact, the daughter-in-law periodically beat the woman. When this matter came to the attention of the police, they discovered that the daughter-in-law put the woman's food on the floor, telling her she was an animal and that she would be required to eat like one.

F. SELF-NEGLECT

It should be no surprise to most people to learn that many older persons neglect their personal needs or that they sometimes abuse themselves. Self-abuse in American society usually occurs where there is a conscious or unconscious indifference to one's personal welfare and well-being. The majority of the self-abuse cases which came to the Committee's attention involved acts of omission. In other words, old people refused to eat or to accept medical attention. However, a surprising number of cases were received which pointed out that senior citizens had actively set out on a course of self-destruction.

Within the context of this report, self-abuse is considered to the extent that such abuse is brought on or exacerbated by the actions of relatives and their attitudes toward their loved ones. Most of the cases received by the Committee involved older people living alone and abandoned by their families. In old age, the social distances between them and their friends and loved ones have grown wider. Loneliness, despair, rejection by one's loved ones often give rise to feelings of worthlessness and serve to snuff out the will to live.

Also included in this category are examples of elderly people living with their loved ones where one or both are physically or mentally incapable of providing the care, food and attention that is needed to sustain them.

—In Louisiana, a 90-year-old man was living in an isolated area abandoned by relatives. He was found with his legs covered with open ulcers. He had 20 to 25 dogs which he slept with to keep warm. Even though his windows were boarded up, a terrible odor permeated outdoors. He would allow no one entrance to his home. It was later discovered that he had not had a bath in over a year; he went only once a month to buy groceries; and the groceries he did buy with his meager income and food stamps was spent on food for the dogs. The older man was eventually convinced to temporarily relocate to a nursing home where it took three scrub-downs to clean the patient.

—Connecticut reported that an elderly woman was living alone in a decaying house which had a putrid odor. She was found to be obese with a grossly swollen, infected and ulcerated leg with deep lesions exposing the bone and pustules extending to her foot. A cousin who had been appointed her conservator three years before did little except pay her bills. Food was delivered, but there was no working refrigerator. Her bed was a filthy, stained, torn couch. Her floors and carpet were stained with blood and drainage from her foot. She denied the need for and refused medical help. The case was finally referred to protective services and the woman was taken to a hospital on probate court order to examine the need for leg amputation.

—An 80-year-old Nebraska woman, abandoned by her family, was reported by a neighbor to be wandering about her yard and clinging to her fence for support—not appearing to know what she was doing. It was discovered by social workers that the woman had not seen a doctor since July, 1977, but was having a prescription filled at several pharmacies. The prescription was to be filled once a month, but at one time it was filled six times in two months at one pharmacy and six times in two months at a second pharmacy. Her medication regimen has since been corrected after consultation with her doctor and family.

II. DIMENSIONS OF THE PROBLEM

The obvious questions from the foregoing examples are: How widespread is the abuse of our elderly? Is the incidence of elder abuse increasing, or is it decreasing? And, what are the consequences for individuals and for society?

In attempting to answer these questions, the Committee reviewed all State studies on the subject undertaken to date; heard testimony from experts in hearings held in Massachusetts, New York, New Jersey, and Washington, D.C.; sent questionnaires to police chiefs from the major metropolitan cities in the United States; interviewed over 200 visiting nurses, home health aides, physical therapists, and social workers, in Maryland, the District of Columbia, New Jersey, and Virginia; surveyed all 50 State Human Service Departments; and solicited the views of the Emergency Department Nurses Association and other organizations representing providers of home health care with respect to abuse of our elderly.

The evidence gathered from all these quarters confirmed the Committee's suspicions: that abuse of our elderly is not a localized problem, but one that occurs nationwide; that cases of such abuse are not just isolated incidents, but occur on a scale about parallel to that of child abuse; and, that the incidence of elder abuse has not been decreasing, but rather, has been increasing over the past five years.

Support for the Committee's judgment that elder abuse is a large and growing national problem can first be found in the hundreds of letters it received from abused seniors and concerned citizens from literally all 50 States.

A second source of support is the testimony received from domestic violence experts, abused elders, intervention program directors, social workers, and many others who testified before the Committee during the last Congress.[1]

At the June 1979 hearing by the Committee in Boston, Massachusetts on *Elder Abuse; The Hidden Problem*, Dr. Thomas H.D. Mahoney, Secretary of the Department of Elder Affairs for the State of Massachusetts, remarked:

> We are only at the tip of the iceberg and there is so much we can learn. The findings of our survey indicate that elder abuse is a very serious problem.

At the same hearing, James A. Bergman, Regional Director of the Legal Research and Services for the Elderly, stated:

> Elder abuse is much more extensive than any of us have thought.

A statement submitted by Marilyn R. Block, Director of the Project on the Battered Elder Syndrome at the Center on Aging, University of Maryland, supported Mr. Bergman's observation:

> Despite the various labels, the grim truth is that there is increasing evidence that middle-aged adult children are physically and psychologically abusing their aging parents in a manner analogous to child abuse. Situations where the older person is victimized by family members will, in all probability, increase as greater numbers of parents live into old age and require care from their children.

Meredith Savage, the Regional Ombudsman at the Connecticut Department on Aging, reported at the Boston hearing that:

> I don't think that any of us realized the enormity of the elder abuse problem until we really started getting into it. What we are finding is that the more people who become aware of protective services for the elderly, the more phone calls we are getting.

Jacqueline Walker, State Nursing Home Ombudsman for the Connecticut Department on Aging, added:

---

[1] The testimonials summarized here are merely illustrative. A great many more can be found in the following hearing records of the House Select Committee on Aging: *Elder Abuse: The Hidden Problem*, Boston, Massachusetts, June 23, 1979; *Domestic Violence Against the Elderly*, New York, New York, April 21, 1980; *Domestic Abuse of the Elderly*, Union, New Jersey, April 28, 1980; and in the joint hearing with the Senate Special Committee on Aging, *Elder Abuse*, Washington, D.C., June 11, 1980.

> Since (our) program has been in effect, there has been an overload of cases reported to our office. More cases than we ever anticipated and more serious than ever anticipated. The ombudsmen have been astounded, sickened and shocked to see the severity of the problems in situations which abound in the community. Problems which until this time, have been unnoticed by agencies and community officials.

A caseworker, Meg Harari, with the Family Services Association of Greater Boston, reported:

> We are concerned that we are seeing only the tip of the iceberg as someone put it before. With more publicity we may uncover more cases, many more cases.

Ms. Walker later added to her testimony:

> As I indicated before, the ombudsmen have been astounded at the severity of the cases that have been running rampant in the community. There is no question in our minds as to the importance of the program. We realize fully that there are endless numbers which are still hidden away waiting to be uncovered. From our brief experience, we can readily say that abuse and neglect are prevalent in all walks of life. There are equally as many problems in affluent neighborhoods as there are in poverty stricken areas, in rural as well as urban areas. The problems are found in all ethnic groups. Women over 75 were more frequently reported than any other age.

Thelma Bailey, Associate Director of the New England Resource Center for Protective Services in Boston stated, "We know that we only see the tip of the iceberg."

Margery E. Ames, Esq., consultant on Public Social Policy, and Robert L. Popper, Chairman of the Committee on Public Social Policy at the Federation of Protestant Welfare Agencies, Inc., testified at the April 1980 New York hearing on Domestic Violence Against the Elderly. Highlights of their remarks follow:

> In recent months, these agencies have noticed an increased incidence of abuse to the elderly which is clearly not confined to those programs providing residential care. This growing problem, horrifying termed "granny bashing," has been highlighted in our local media, on television, and in research studies conducted in Boston, Maryland, and Rhode Island; all attest to the growing awareness on the part of professionals of this hidden problem.
>
> The potential for abuse in residential settings such as adult homes and nursing homes has, for some time, been recognized, and many States (such as New York) have made first attempts at combatting elderly abuse in those settings. However, we believe that the potential, and actual, abuse of the elderly in the community and in their own homes is just as real but less well recognized. As our population lives longer due to the medical advances of our society, and as the segment of the population over 60 becomes a larger percentage of the total, it can be expected that there will be an increasing incidence of domestic violence, or physical and psychological abuse and exploitation of the elderly by relatives and friends.

Congressman Mario Biaggi, who chaired the New York hearing, remarked: "Domestic violence against the elderly is a burgeoning national scandal."

Congressman Thomas A. Luken, who also attended the hearing in New York, expressed his concern:

> Now that we have recognized (elder abuse) as a phenomenon which is occurring—and it is occurring widely in this country—it certainly is something for us—a matter of national policy to determine what the cases are.

The Director of the Brooklyn Senior Citizens Crime Assistance and Prevention Program added, "Although the problem of elder abuse will only get larger, society has for the most part ignored the problem."

Lou Glasse, Director of the New York State Office on Aging, agreed:

> However, it is only recently that we have begun to learn about incidents of physical abuse and violence against the elderly in their own homes by members of their own families. It would seem that the same savagery shown the elderly on the streets by criminals who prey on the vulnerable has permeated into the home.
>
> The home, conceived as a place of refuge, turns out to be a very dangerous place for some older persons. Researchers estimate that 10 to 20 percent of families in the United States suffer some incident of family violence and the elderly, once respected and venerated, do not escape victimization.

In the Washington, D.C., June 1980 joint Senate and House Aging Committee hearing on Elder Abuse, Senator Lawton Chiles stated in his opening remarks, "We know there is a problem and it seems to be a growing one."

Senator Pete Domenici supported Senator Chiles observation:

> The syndrome of "the battered elder" appears to be quite prevalent—some studies reveal that it rivals child abuse in frequency where statistics indicate 600,000 cases a year on the average.

And, Senator David Pryor noted, "A recent study suggests that elder abuse may occur as frequently as child abuse."

Dr. Suzanne Steinmetz of the University of Delaware, tried to quantify the incidence of such abuse, ". . . between 500,000 and 1 million parents are abused in any given year and that number may increase threefold as inflation drives more people to move in with their families."

Marcia K. Standley, an adult protective service worker in San Jose, California, reported at the Washington, D.C. hearing that "finding the key to effective prosecution is essential because senior abuse is now so easy to get away with that it is now becoming epidemic."

A third source of support is found in the responses to a May 13, 1980 questionnaire the Committee sent to 30 police chiefs representing major U.S. metropolitan cities [2] asking them to report their experiences with elder abuse. (The questionnaire can be found in Appendix V of this report). Twenty-two, or about 75% of the police chiefs, who represent approximately 27 million United States citizens, responded to the Committee's questionnaire.

The police chiefs who responded to the Committee were extremely cooperative in supplying the Committee with the requested information in a timely fashion and many expressed their concerns with respect to the abuse of the elderly. For example, the police chief of the City of Buffalo stated in his correspondence to the Committee, "Thank you for your interest in the Buffalo Police Department, by contacting us for information on this important social problem." The police chief from the City of New York stated, "Be assured of our continued cooperation in this and other matters of mutual concerns." The Dallas, Texas police chief even offered a recommendation with respect to needed action in this area, "As noted in the summaries, financial and physical abuse are often inseparable. In order to care for elderly parents, and to alleviate the problem, community resources will have to increase."

Question 1 of the survey asked the police chiefs if they or their officers encountered situations where family members have physically abused or grossly neglected their elder relatives. The majority of the police chiefs, 64 percent, said they had encountered such cases of abuse. Another 18 percent said they did not know whether such abuse is encountered, and the remaining, only 18 percent, said they did not believe so.

Question 2 sought to determine how frequently such abuse occurs in the police chief's particular jurisdiction. About two-thirds of the police chiefs reported that such abuse occurs, with over half that number agreeing that it occurs frequently. About one-fourth, or 28 percent, of the police chiefs who responded said they simply did not know how frequently such abuse occurs, either because they do not gather such statistics, are not equipped to gather and analyze such statistics, or because older abused victims are less likely to report they have been victimized. For example, the New York Police Department advised the Committee that:

> Unfortunately, the New York City Police Department, in recording its crime statistics, does not gather information required in your questionnaire. . . .

Lansing, Michigan Police Department stated that although they do not have such data available, there is a need for such data:

> There needs to be a formal mechanism for data collection as well as a viable referral service for those of us in law enforcement. . . .

---

[2] Police Chiefs from the following metropolitan cities responded to the Committee's questionnaire: San Antonio, Texas; Columbus, Ohio; Minneapolis, Minnesota; Kansas City, Missouri; Pittsburgh, Pennsylvania; Chicago, Illinois; the District of Columbia; Denver, Colorado; Detroit, Michigan; Phoenix, Arizona; San Francisco, California; Milwaukee, Wisconsin; Buffalo, New York; New York, New York; Los Angeles, California; Newark, New Jersey; Honolulu, Hawaii; Indianapolis, Indiana; Lansing, Michigan; Atlanta, Georgia; Dallas, Texas; and, Memphis, Tennessee.

Kansas City, Missouri Police Department added:

> The Kansas City, Missouri Police Department does not gather statistics regarding crimes against the elderly that were committed by members of their families.

Pittsburgh police indicated the same situation: "Statistics on these types of incidents are not maintained in a specific category." And, the Detroit Police Department stated: "There is a lack of empirical data to make accurate conclusions regarding the abuse of the elderly by family members."

The San Francisco Police Department also does not keep such statistics:

> The San Francisco Police Department does not keep statistics on victims of aggravated assault by age and/or relation of the suspect. There were 3,571 aggravated assault cases reported in 1979 and there have been 1,302 aggravated assaults reported for the first four months of 1980. The Officer-in-Charge of the investigators assigned to aggravated assault cases has told me that such incidents do occur but at a rate that would cause a separate statistical study to be made.

The Phoenix Police Department reported:

> We are not able to respond to your questionnaire as the information requested is not readily available from our information gathering systems. Although it is almost certain that the type of abuse you are seeking to identify exists in our area, our lack of data on the subject would not permit us to furnish valid information for your study.

A number of police departments indicated that they felt that many elder abuse cases are not brought to their attention, as older victims are less likely to report they have been abused. For example, the City of Memphis, Tennessee Police Department wrote the Committee:

> My opinion is that the real danger of abuse on the elderly by family members is that it is so seldom reported. Without question, we assure that much more of it goes on than ever comes to our attention.

Honolulu agreed that elder abuse goes unreported in their jurisdiction:

> These ethnic groups (Japanese, Chinese, Filipinos, Portuguese, Samoans, Koreans, Hawaiians, etc.) would be very hesistant to report family difficulties of any kind, rather preferring to explore personal problems in private and take care of such matters themselves.

Columbus, Ohio police noted:

> While wo do feel as though these problems occur but are not reported due to the fact that parents do not want to implicate their children or do not know who to turn to for assistance.

Minneapolis Police Department agreed with the Columbus police observation:

> A common comment made by many police officers regards an attitude of many elderly persons and the reporting of abuse. The problem is in the reporting, or more specifically, the lack thereof. Other family members and neighbors are reticent and the elderly would appear to be either unaware of the extent of the abuse, unable to report the situation, or simply resigned to a situation because of senility, fear, or embarrassment.

Question 3 asked police chiefs if they would say the incidence of this problem has increased over the last five years. One-third of the police chiefs reported that abuse of the elderly by family members has increased over the last five years. Almost half of the police chiefs could not tell the Committee whether such abuse was increasing even though they indicated that it does occur. Only one-fourth responded in the negative.

Question 4 of the questionnaire asked the police chiefs to provide the Committee with examples of financial abuse of the elderly which had come to the Department's attention. The following examples are illustrative of cases frequently brought to the attention of police departments nationwide:[3]

—An Atlanta police report notes that, "Mrs. M is 60. Mr. B, her son, is 27. She has prosecuted him four times for simple battery on her. He does not work. She is terrified of him and does not let him know where she lives. She also is very worried and concerned that he cannot get ongoing in-patient treatment."

---

[3] A number of the cases supplied by the Police Chiefs were cited in Section I of this report. The majority can be found in files maintained by the House Select Committee on Aging.

—The Dallas, Texas police chief reported: "We had a case of an elderly, ill woman who shared a duplex with her middle aged son. The man was an alcoholic and often opened the house up to neighborhood winos. He also sexually abused his mother and drained her bank account. We secured legal assistance and the situation was resolved when the mother was placed in a nursing home and the son died shortly thereafter.

—The Memphis, Tennessee police chief gave numerous incidence of elderly abuse, including: "On May 9, 1980, the Memphis Police Department responded to an armed robbery complaint. The investigation revealed that two elderly males, Mr. X, 71 years of age, and Mr. Y, 82 years of age, lived at this address. The son of Mr. X, accompanied by a companion, had forced his way into the home and robbed both of the elderly men." And, "In December of 1979, a 70-year-old male and his 65-year-old wife were fatally attacked by a nephew. Fatal injuries were inflicted with a knife."

About the same time the Committee sought case histories from police departments, *Parade Magazine* quoted Chicago homicide investigator, Victor Tosello, as mentioning:

> . . . cases involving a grown child beating up on parents happen all the time. It's not at all unusual for these kinds to beat up on their elder, who are at a disadvantage. Parents are terrified of their children.

Question 5 asked the police departments if they had ever encountered situations where family members have financially abused their loved ones. Over 50 percent of the police chiefs said that they have encountered such abuse. Hawaii reported that "most cases are probably financial and mental abuse," and San Francisco added, ". . . undoubtedly, mental and financial abuses occur, however, those areas of abuse probably come to our (police) attention less often than they would come to the attention of family doctors, mental health clinics, or the District Attorney's Family Affairs Office." Another one-fourth of the police departments indicated they did not have the data available to determine whether such abuse occurs and the remainder indicated they had not encountered situations which involved elder abuse.[4]

Question 6 asked the police chiefs how frequently situations involving the financial abuse of the elderly occur in their jurisdiction. Although a number of police chiefs felt that such abuse occurs on a widespread scale, the majority agreed that such situations are not likely to be brought to their attention, but rather to the attention of other city authorities. Question 7 sought to determine whether the police believe that financial abuse has been increasing over the past five years. It is interesting to note that even though the police are not likely to encounter such abuse, over one-third felt that it was increasing, one-fourth felt it was not, and the remainder simply did not know.

The fourth source of support was provided by studies undertaken in a number of States across the country over the past two years on the subject of elder abuse [4]

MASSACHUSETTS

In 1979, the Massachusetts Legal Research and Services for the Elderly headquartered in Boston, conducted a State-wide mail survey of about 1,000 social and protective service workers, hospital and legal personnel, police officers, and other professionals likely to encounter abuse of the elderly. The survey uncovered 183 cases, or citings, of abuse.

Professionals and paraprofessionals in the survey cited bruises and welts in about half of the cases, and debilitating mental anguish in 40 percent of the cases. Thirty-four percent of the injuries reported involved minor trauma, while 7 percent were major, including skull or other fractures and/or dislocations. Neglect was sometimes of a serious nature, but more often than not was left unclarified by the respondent. Twenty cases reflected primarily verbal harassment, 16 involved malnutrition, 8 were of financial mismanagement, such as the withholding of rent or food money, and 7 involved unreasonable confinement. One case of oversedation was reported as well as one case of sexual abuse.

---

[4] "Recent studies of elder abuse differ from one another in their categorization of types of abuse, but all included a category for physical abuse (hitting, slapping, burning, etc.) and another for psychological abuse (shouting, threatening, intimidating). Other types of maltreatment assessed withholding food or medicine; extorting money or property; and sexual abuse. Some researchers have attempted to distinguish between abuse and neglect while others consider all forms of maltreatment to be abuse." Fowler, Jan. *Domestic Violence: Elder Abuse*, Library of Congress, Congressional Research Service, Feb. 6, 1981, page 2.

Survey results indicated that the largest single age group represented in the cases were elders over 80 years of age. The least likely to be abused were those 65 and under. In general, the data tended to support the conclusion that victims of abuse are more likely to be very old, 75 and over, female, and suffering from a mental or physical disability which prevented him or her from meeting daily needs.

In the majority of the cases, the abused elder lived with someone else, usually the abuser who, in the majority of the cases, was a close relative.

Twenty-eight percent of the abuses cited indicated the abuser was suffering from either alcoholism or drug addiction at the time of the abusive act or acts. However, in the majority of the abuse cases, stress associated with caring for the elderly was the major factor precipitating the abusive conduct.

Researchers felt that many cases of such abuse go unreported because the elder victim is reluctant to acknowledge the problem, either out of fear of retaliation from the abuser, feelings of kinship and love for the abuser, or simply as a refusal to accept services.

MARYLAND

A similar mail survey of the State of Maryland was undertaken by Marilyn Block at the University of Maryland Center on Aging in 1979.

The Maryland study was aimed at determining the feasibility of implementing a variety of approaches to investigating the nature and incidence of the maltreatment of the elderly including neglect, physical and mental abuse. Victims of abuse were defined as those individuals who had sustained physical, psychological, material or medical abuse in the home; had a repeat history of such injury; were at least 60 years of age; and resided in the home of a son or daughter, other relative, or with a caretaker. Physical abuse was defined in terms of malnutrition or injuries such as bruises, welts, sprains, dislocations, abrasions or lacerations. Psychological abuse was defined in terms of verbal asault, threat, fear, and isolation. Material abuse involved theft or misuse of money or property. Medical abuse was defined as the withholding of medications or aids required by the victim, such as false teeth, glasses, or a hearing aid.

Three populations were surveyed: (1) agencies which interfaced with elders in greater Washington, D.C., Standard Metropolitan Statistical Area, and Baltimore, including county police departments, adult protective services agencies, senior centers and home care programs; (2) nurses, doctors, social workers, and senior program personnel in the greater Washington, D.C., area and the Standard Metropolitan Statistical Area; and (3) elderly persons in the same areas. (The social agencies and elderly individuals contacted for this survey had very low response rates and the investigator did not recommend these two sources for studying abuse). Bruises and welts were present in 31 percent of the cases of abuse reported, bone fractures in 8 percent, verbal assault in 58 percent, and misuse of money and property in 46 percent. In this analysis, categories of abuse were not mutually exclusive, reflecting the fact that victims often suffer more than one type of abuse.

The survey suggested that if the rate of elder abuse nationwide was similar to the rate in Maryland, then the incidence of about 4 percent, or nearly a million cases, could be expected to occur nationwide each year. While this would mean that elder abuse occurs less frequently than spouse abuse, it would appear to occur as frequently as child abuse.

MICHIGAN

A different approach was taken by researchers, including Richard Douglass, at the University of Michigan's Institute of Gerontology in 1979. They interviewed more than 250 professionals in 5 Michigan study sites, representatives of metropolitan, suburban, agricultural and isolated areas, heterogeneous ethnic and varied socioeconomic sub-populations. The following professionals were asked about their perceptions of the quality of care of elder people in the home: police officers, physicians, nurses, clergy, social workers, mental health workers, direct service providers to the aging, morticians, lawyers, judges and coroners as well as nursing home administrators, nurses and aides.

The majority of the respondents felt that the older person's needs were being adequately met in the home. But about 10 percent of those surveyed indicated that the needs of elders at home were not being met by their caretakers. When questioned about specific forms of maltreatment, one-fourth of the respondents felt that homebound elderly are frequently or always ignored and isolated by their caretakers, many also felt that verbal and emotional abuse occurs frequently or always, and 8 respondents felt that physical abuse occurs frequently or always.

It is interesting to note that interviews with nursing home officials elicited virtually no admission of any form of neglect or abuse of nursing home patients. This survey finding is in sharp contrast to numerous hearings held by the House and Senate Committees on Aging.[3]

The Michigan report on the survey concluded:

> While widespread neglect or abuse of dependent and vulnerable adults is not suspected on the basis of this study, *the prevalence of such maltreatment is expected to be substantially greater than is commonly thought to be true. Certainly the prevalence suggested by the respondents in this study is large enough to justify serious social and governmental concern, including immediate action and considerably more research.* (Emphasis added).

OHIO

Another study of elder abuse was undertaken by the Cleveland, Ohio Chronic Illness Center to determine the incidence and nature of abuse situations in cases accepted for direct service by the Center on the Cuyahoga Hospital System serving aged and chronically ill clients in the Cleveland community. The study, conducted jointly by Elizabeth Lau and Joseph Kosberg in a 1-year period in 1977–78, found that 9.6 percent of the 404 patients aged 60 and over seen by the Center in that one year period showed symptoms of abuse.

In the Ohio study, the abuse of the elderly was broken down into physical (experienced by 29 persons); psychological (experienced by 20 persons); material, i.e., theft or misuse of property or money (experienced by 21 persons); and violation of rights, e.g., being forced from their residence (experienced by 7 persons). Most patients had experienced more than one kind of abuse.

It should be noted that the Chronic Illness Center's caseload consists mainly of serious ill or disabled individuals and thus is not representative of the over-60 population as a whole. Therefore, it would not be advisable to apply the 9.6 percent abuse rate to the entire senior population.

In concluding their survey findings, the researchers noted:

> *The problem of the abuse of the elderly by informal care providers is a neglected and hidden one which requires attention sufficient to initiate large scale action in legislation and effective programming.* (Emphasis added).

FLORIDA

The Department of Health and Rehabilitative Services in Florida gathered statistics on elder abuse cases in Duval County for a period of six months, November 1979 to April 1980.

Of the total 49 reported cases during the six month period, 24, or 49 percent, were considered to be physical abuse cases; 18 reported cases, or 36 percent, were exploitation; and 7 cases, or 14 percent, were neglect cases.

Seventy-five percent, or 36 cases, reportedly involved relatives as the perpetrators. Seven cases, or 14 percent, involved caretakers; 5 cases, or 10 percent, were acquaintances; and 1, or 2 percent, was unknown.

Of all the reported cases, over half were unsubstantiated; another 12 percent were substantiated but declined help; seven cases, or 14 percent, were substantiated and received assistance; 18 percent of the cases were strongly suspected or appeared likely to involve actual abuse but no conclusive evidence was found. Only one case reported appeared probable, the victim denied assistance.

Thirty-two percent of all cases were reported in April, 16 percent in each of the months of December, January and March. Ten percent were reported in November, and 8 percent were reported in February.

---

[3] For supporting documentation, consult House and Senate Committees on Aging hearing records relating to abuses in nursing homes, on file with the Committee.

In providing the Committee with these statistics, William A. Frye, Jr., added these comments:

> *I am glad that abuse against the elderly is recognized. The interest shown by the Committee will make the public more aware of abuse against the elderly. The major problem of those involved in abuse is the fact that the public is not aware enough to report such incidents. Until the reporting becomes more substantial it will be difficult to establish preventive measures. As a worker in this field I am constantly made aware of individuals who have never been aware that abuse of the elderly exists. It is hoped that the Committee will establish public awareness of this problem and help set up preventive measures. If I can be of further assistance please do not hesitate to call upon me.* (Emphasis added).

MAINE AND NEW HAMPSHIRE

In 1979, researchers in Southern Maine and New Hampshire, Judith McLaughlin, Joan Nickell, and Linda Gill, conducted a telephone interview survey of 31 Maine and New Hampshire health, social service, legal, and civil rights agencies to determine whether abuse and neglect of the elderly was perceived as a health problem in these two States.

The study revealed that 29 cases, or 4.5 percent, of all clients over 65 years of age were known to have sustained some degree of abuse or neglect over an 18-month period. The existence of all 5 types of abuse was indicated: physical abuse, physical neglect, psychological neglect, material and financial exploitation and violation of human and civil rights.

Findings were that recognition of a once unrecognized problem in Southern Maine and New Hampshire had increased, but further diagnosis and documentation is needed to establish its magnitude and severity. Data was currently not available to establish incidence or prevalence with certainty, but the investigators believe from their study data and literature reviewed that the problem can be generalized to some extent to the entire population in the United States. The elderly victim was more than 65 years old, and more often over 75, functionally disabled, roleless, dependent for at least some basic survival needs, lonely, and fearful. She resided in a home setting of varying resources with or near one or more of her adult children, who may themselves be over 60 years of age. The study concluded that the time of abusive or neglectful actions remained unclear, but appeared cyclical, precipitated by intolerable stress, often expressed in substances abuse as well as violence and neglect of others.

The study found a need for intra-agency coordination of supportive services already present in the areas surveyed, and that community health agencies can contribute to the detection and prevention of elderly abuse and neglect in the populations they serve.

In summarizing their report on elder abuse, the Maine and New Hampshire researchers concluded:

> *Results of the telephone interview survey of 31 Maine and New Hampshire health, social service, legal, and civil agencies revealed a developing consciousness of the problem. The sense among all contacted was that the problem of elderly abuse and neglect has not had sufficient definition or attention, and that cooperation among health workers, social service, advocacy, and law enforcement agencies with official arms of the executive branch of government was possible and desirable.* (Emphasis added).

Newspaper investigative exposes provide a fifth source of support,[5] such as the *Minneapolis Tribune* investigatory series by Cammy Wilson, which ran from June 1978 through August 1979.

This *Tribune* series describes the findings of a six-month long newspaper investigation into probate procedures in Hennepin County. The articles examined the disposition of estates of individuals who, in the opinion of the probate court, could no longer manage their affairs, necessitating the appointment of a guardian or conservator, usually a son or daughter, to manage the elderly individual's estate. The series described how the elderly person's estates were sold for relatively low prices, at least lower than the assessed value, and resold for over twice their sale prices shortly thereafter. The gains realized from these transactions were not passed on to the elderly but were kept by the conservator, while publicly funded programs continued to pay for the care of the elderly person. The following was just one of seven examples reviewed in the series:

---

[5] The *Minneapolis Tribune* investigate services on elder abuse is merely illustrative of the numerous exposes that have appeared in major newspapers in the past few years. Exposed by the *San Francisco Chronicle*, the *Boston Globe*, the *New York Times*, etc., are available for review in the Committee's files.

> Mrs. O was a nursing home patient whose son was first appointed as her conservator; later an estate management corporation was appointed. The latter sold the patient's home to the son for $26,200. The son rented it out for a year, then sold it for $37,000. Mrs. O received $72 from her estate of $30,000, which included the house, social security and veteran's benefits, after expenses and closing costs were paid. She became a welfare client before her death in 1979.

A sixth source of support was provided by the U.S. Postal Inspection Service which conducted an investigation into alleged violations by boarding home owners who were serving as caregivers for their elderly residents, at the request of the Hon. S. William Green who formerly served on the House Select Committee on Aging.[7]

The Postal Service investigation began in 1979 after Congressman Green voiced concern regarding the possible financial exploitation of elderly in various unlicensed adult homes in Queens, New York and elsewhere in New York City.

The Postal Service's investigation confirmed Congressman Green's suspicions. In 1980, a Queens couple was charged with operating a group of unlicensed substandard homes for former mental patients and systematically forging and stealing government old-age or disability checks sent monthly to their tenants. The couple was alleged to have unlawfully cashed checks that might have totalled as much as several hundred thousand dollars since the early 1970's.

A review of the case by the Committee revealed that the owners had exercised financial control over the tenants in these homes by placing padlocks on the houses' mailboxes and collecting the tenants' social security, SSI and other public assistance checks. In some instances, on the mailboxes were printed instructions to the postman to NOT give mail to the house residents.

In other instances, checks would continue to be forged and cashed long after an elderly resident of the home had died. For example:

> On May 9, 1979, the deceased body of Mr. X was found in his room at one of the owner's homes. From May through August, 1979, checks payable to Mr. X continued to be endorsed and cashed by the owners.

In his letter to the Postmaster General requesting the investigation, Congressman Green stated:

> If the allegations are true, they represent a cruel violation of the rights of individuals who are attempting to overcome difficult hurdles in their return to normal social life. I believe it is the responsibility of appropriate Federal agencies to assist local authorities in the investigation of such circumstances and to prosecute offenders whenever Federal laws are violated.

Testimony presented to State Legislatures on the subject of elder abuse is a seventh source of support.[8]

In a hearing on elder abuse conducted by the Illinois House Human Resources Committee on January 29, 1981, the Task Force on Adult Abuse of that Committee heard testimony from Idelle Goode, the Director of the City of Chicago Office for Senior Citizens and Handicapped, on the subject of elder abuse.

In her testimony, Ms. Goode noted that her office encountered situations involving the abuse of elderly by their loved ones and indicated this abuse takes the following forms: exploitation, intentional overuse of drugs to pacify older persons, psychological and emotional cruelties, and actual physical mistreatment.

She urged the Committee to focus on abuse prevention. Social service agencies, community colleges and other educational institutions, she felt, should conduct public awareness campaigns on the elder abuse problem. Agencies serving the elderly, she added, should recognize the need to provide counseling to caretakers of the elderly, ranging from intensive individual sessions to more informal nonthreatening discussion groups on coping with the stress of caring for a sick older relative.

---

[7] The U.S. Postal Inspection Service advised the House Committee on Aging that this particular example of widespread financial exploitation of the elderly is far from unusual. Their files contain other cases involving the forgery of government checks, including social security, SSI, disability and other old age benefits. Frequently older persons are deprived of necessary income by their caregivers and loved ones and those entrusted with their care.

[8] Testimony before the Illinois State Legislature is merely illustrative of numerous hearings which have been held across the country to ascertain the extent and nature of the problem as well as to gather information with respect to a recommended course of action for the States to undertake. Such testimony has been retained and is available for viewing in Committee files.

In concluding her testimony, Goode stated:

> . . . the delicate nature of the family unit and complexity of relationships hamper public authorities in their efforts to address the abuse problem, and stiff penalties may or may not be appropriate depending on the situation. The lack of data stemming from the fact there is no mandatory reporting requirement in Illinois presents a systematic survey of the scope of elderly abuse in Chicago. However, a study of adult abuse has recently been commissioned by the Illinois Department on Aging.

Grand jury reports and/or presentments have provided the Committee with an eighth source of support.[9]

During the August 1980 term of the Westchester County Grand Jury, White Plains, New York, a report was submitted containing findings of fact, conclusions and recommendations with respect to an investigation, over a period of four months, which centered around the activities of a woman resident of the County of Westchester, referred to as Mrs. X. The Grand Jury, in its report, found Mrs. X and those with whom she associated to be engaged in long-standing and repeated wrongful activity, involving the taking of assets from elderly and incompetent persons. Mrs. X was a caretaker of elderly residents living in her adult home. The following is an example of the financial abuse encountered by Mrs. X's elderly residents:

> Ms. D was an over-80-year-old woman who had for some years been senile, but had assets of approximately $500,000 controlled by a midwestern bank. She lived as a "paying guest" in the home of a sister of Mr. and Mrs. X, operators of an adult home. Mr. X approached "Mike," the 46-year-old boyfriend of his sister-in-law and advised him of Ms. D's assets, told him he was "sitting on a golden egg" and that a way must be arranged to get Ms. D's money. The method was for "Mike" to marry Ms. D which he agreed to do, and also agreed to split her estate with Mr. X and Mrs. X's two sisters. They told Ms. D her deceased brother, to whom she had been close, wanted the marriage to occur.
>
> The marriage took place in March 1973, and approximately one month later, Mrs. X's sister (Mike's girlfriend) contacted a local attorney suggesting Ms. D wished to draw up a will. The attorney met Ms. D twice; a will was drawn up, signed and witnessed. Seventy-five percent of Ms. D's estate was left to Mike, and eight and one-third percent to each of three children of a woman with whom Ms. D had previously lived. She died less than 2 years later from generalized arteriosclerosis. The death certificate was signed by the doctor who services the X's Adult Home.

The Grand Jury commented in its conclusions:

> Old age is, for some of us, a time to reap the benefits of our years of productivity, to enjoy one's family, and to expand our experience at a time when the constraints of the work-a-day world and family responsibilities are lifted from us; a time to enjoy the dignity and freedom this time of life affords. For others of us, not so fortunate, these last years will find us ravaged by illness and debilitated of mind, though, hopefully, not spirit. It is these last of us, especially those without close family members to care for us or supervise others in caring for us, who may fall prey to the predatory activities of individuals like those whom we have been investigating.

Independent studies provide a ninth source of support, such as the University of Iowa and Washington University-based studies of elder abuse.[10]

The University of Iowa Gerontology Center's Iowa Gerontology Model Project was funded in 1978 by AoA to develop a system to assure that the functionally dependent have the most appropriate level of care with support services and to live as independently as possible. In attempting to accomplish this task, the project director, Dr. Helen Hageboeck, uncovered previously unknown abuse problems. During the first 6 months of 1980, the Project discovered that 20 percent of the 105 in-home assessments they conducted involved physical abuse or severe neglect. Of the abused elderly, they reported that 90 percent lived with the abusers. Forty percent of the abusers were spouses, 50 percent were their children or grandchildren, and 10 percent were caretakers hired by family members. Eighteen percent of the elderly abused were assaulted by more than one relative. *The Iowa Project has experienced an increase in number of abuse cases referred to it since it began.*

---

[9] Numerous Grand Jury reports and presentments have been reviewed by the Committee involving abusive situations encountered by older Americans at the hands of their caretakers. The Westchester County Grand Jury Report discussed here is illustrative of many of these other Grand Jury findings.

[10] Numerous other experts from institutions of higher learning have undertaken similar research projects relating to elder abuse, but could not be summarized here. See Committee files for further information.

Hageboeck reported to Iowa papers which covered the preliminary findings of the Project's study, that "the project questionnaire originally wasn't designed to detect cases of abuse, but after incidents of such abuse were discovered during the first months of interviews, the questionnaire was revised." She further stated:

> We found abuse quite frequently, so we had to revise our questionnaire. Since that revision, we have determined 22 of 105 cases were abuse cases.

An example of the abuse the project encounters follows:

> An elderly woman was found to be living with her son who was unemployed because of disability. The elderly woman, when hospitalized for hypothermia and pneumonia, was found to be acutely ill, have little stamina, totally dependent for all daily living requirements, had swelling of the hands and legs, bruises on her left pubic region, right hip, face, shoulders, upper abdomen and scarlike lesions on her arms and hands, and an open leg ulcer on her shin. At first she refused to discuss the bruises saying they were the result of a fall. A relative later confirmed suspected abuse and indicated repeated abuse was sustained by the elderly woman over the years at the hands of her son.

At the George Warren Brown School of Social Work at the Washington University in St. Louis, Missouri, Dr. Eloise Rathbone-McCuan undertook a study of intra-family violence which included a discussion of geriatric abuse. The study described 10 cases of elderly and/or disabled persons from ages 51 years to 82 years whose family members had abused or neglected them, including the following:

> . . . A malnourished 80-year-old woman was treated in the emergency room after being kicked in the abdomen by her nephew with whom she lived . . . A 72-year-old woman was given emergency room treatment after being hit with a phone by her daughter . . . An elderly woman became weak and unable to walk after receiving care from her daughter . . . A 71-year-old woman whose husband was her caregiver was comatose and had bed sores all over her body . . . A 77-year-old diabetic was repeatedly beaten by her son . . . A 74-year-old woman was confined to a basement and inadequately fed by her son and daughter-in-law . . . A 71-year-old woman was physically attacked by her son . . . An 82-year-old woman was regularly struck by her daughter and son-in-law . . . Another 80-year-old woman received repeated facial injuries from her daughter . . .

In concluding her report, Dr. Rathbone-McCuan commented that it is important to further investigate the possibility that the aged are victims of abuse and their situations similar to wives and children who are abused and/or neglected.

A tenth source of support came from adult protective service officials themselves. The comments from the following officials are illustrative of many others who have expressed similar concerns to the Committee.

Phyllis Thompson, Supervisor of the Adult Protective Services in Richmond County, Georgia, wrote the Committee in June 1980:

> Your recent comments and interest in abuse of the elderly were especially meaningful to me as a supervisor of adult protective services in Richmond County, Georgia. Even though referrals for this service are continuously increasing, *I believe we are barely touching the surface in identifying and protecting abused elderly.*
>
> We have found incidents of elderly being locked in closets, utility sheds, and chicken coops, deprived of food and clothing, sexually abused, and deprived of medical care and financial aid. One particularly heinous report concerned an elderly cancer patient whose daughter-in-law forced her face into her own excrement.
>
> Those of us involved in adult protective services are hampered by many obstacles. Some of these obstacles require Federal legislation to ameliorate. Some of the problems we encounter are:
>
> 1. Lack of public awareness of the scope of the problem or who to call for help;

2. Funding for services to the elderly is channeled through several different Titles of the Social Security Act and administered through many different agencies. I believe greater impact could be realized by unifying funding and administration. For example, in the District of Columbia, on K Street alone, there are three different agencies serving the elderly;
3. I believe elderly abuse should be a felony as is cruelty to children. Failure to report elderly abuse to a protective service agency should be a misdemeanor;
4. In many States, and Georgia is one of these, abused elderly cannot be removed from dangerous environment without having them declared incompetent. Like the old cliche, this is indeed adding insult to injury.

Karel Cornwell, Adult Protective Service supervisor for the District of Columbia wrote the Committee in June 1980:

> Of the 153 clients served by our agency during the first six months of fiscal year 1980, 112 were 65 years of age or older, including . . . a sexually abused and exploited mother-in-law in her 70's and a 106-year-old woman bilked of $2,450 by her church deacon. The typical senior citizen in need of protective services is frail, friendless or forgotten, sometimes showing signs of senility.

Doreen Getsinger with the Department of Social Service Assessment Center in Montgomery County, Maryland offered this observation:

> I would stress that our service is for all adults, 18 or above. We do not separate out those over 65 or over 60, and we provide the services to all age levels. However, 75% of our clientele is over 65.

An eleventh source of support came from the Emergency Department Nurses Association, headquartered in Chicago, Illinois.

In a June 1980 letter to the Committee, Nadine A. Davis, Director of the Member and Chapter Services of the Emergency Department Nurses Association, stated:

> The coordinator of our July Packet on Elderly Abuse has asked that I contact you specifically to express EDNA's willingness to assist in collecting data about the incidence of elderly abuse. It has become clear during the development of our materials that the lack of information and statistics in this area is appalling—making the task of increasing public awareness much more difficult. Since it is a problem which is not a stranger to the emergency departments in which our members work, we would like to offer the services of the EDNA members in the collection of data needed in this important area.

Associations representing in-home service providers, visiting nurses, physical therapists, social workers, and home health aides provided the Committee with a twelfth source of support.

In October 1980, Ms. Dorothy Nelson, Director of the Visiting Nurses Association for the District of Columbia and Maryland, and Mrs. Libby Gittenstein, a mental health consultant for the Visiting Nurses Association in the same area, offered to assist the Committee in collecting data on the incidence of abuse encountered in the area served by their Association. In addition, the Director of the Visiting Nurses in a New Jersey County also assisted the Committee in this effort.

In all, over 206 visiting nurses, home health aides, social workers and physical therapists were asked to answer a questionnaire (See Appendix VI of this report) and to provide the Committee with case histories of abuses they had personally encountered. The majority of those responding to the questionnaire felt that abuse of the elderly does occur and at an increasing rate. The visiting nurses staff provided the Committee with numerous descriptions of elder abuse cases they had personally encountered ranging from abusive situations resulting in the death of the older victim to obvious neglect of the elderly by their relatives and caretakers. Many of these cases were summarized and incorporated into Section I of this report.

William Halamandaris, Executive Director of the National Association of Home Health Agencies, which represents visiting nurses and in-home care providers for the elderly nationally, provided the Committee with a statement of his views on the problem of elder abuse:

> . . . Abuse of the elderly has been continually reported by members of our Association, and these cases appear to be not localized, but are occurring nationwide. We hear, time and time again, of older persons who are victimized by their family members and those entrusted with their care.
>
> . . . Typically, we encounter situations where older persons are living with their family members and creating stressful situations. The older person has numerous needs which must be continuously met creating a burden on their children in many instances. The frustration created by their inability to adequately meet their older family member's needs often turns into violence. Unfortunately, these situations are happening with frightening frequency . . .

A thirteenth source of support came from local organizations and associations providing services to senior citizens across the United States.

In June 1980, Michael Gilfix, Director of the San Jose, California Senior Adults Legal Assistance project, contacted the Committee regarding his concern about elder abuse:

> We have, for example, some clients (or family members) who may be interested in testifying about their own experiences. One person—a son—literally watched his mother die in a home while the staff refused to do anything . . . More generally, we encounter numerous examples of abuse. In addition to examples of physical abuse and neglect in nursing homes, we see examples of financial exploitation by persons entrusted with the care of elders . . .

The Aroostook Regional Task Force of Older Citizens, Inc., of Presque Isle, Maine, wrote the Committee in June of 1980:

> I want to extend my appreciation to you and other House Select Committee on Aging members for holding hearings and calling national attention to the unrecognized social problem of abuse of older people. Those of us working directly in the field have been trying to get recognition of this apparently growing problem and, until the Committee hearing, little public response has been heard.
>
> Our nation has recognized and reacted to the reality of child abuse with protective legislation, educational programs and millions of dollars. Yet, abuse of older people seems to be unrecognized and falls into the lowest of priorities at both the Federal and State levels. In fact, here in Maine, the Department of Human Services plans to increase available Title XX funds for child abuse and protective services while decreasing currently inadequate funds for adult protective service.
>
> Please continue your work on behalf of those older adults who suffer torture and abuse on a daily basis. We see the problem but, because of insufficient funds, lack of public interest, and no legal support, can do little. We need a Federal legal initiative to combat this problem.

In Manhattan, the Committee was advised that a parents' group has opened a "Parents' Center" where abused parents can meet to discuss their problems.

John Von Glahn, Executive Director for the Family Service Association of Orange County, California, specializes in family-abuse problems. He stated in an interview with *Newsweek*:

> Even a battered child is more protected. During the course of their activities they come in contact with all kinds of people—school teachers, nurses and doctors. About the only place many of the elderly can call for help is the police department, and few will sign an arrest warrant for their own son or daughter.

The Missouri Association of Prevention of Abuse to Adults (MAPAA) wrote to the Committee in June of 1980:

> MAPAA grew out of a deep sense of frustration experienced by both professional members of the St. Louis community (social workers, priests, ministers, police, and others) as well as citizens of the larger community immediately involved in trying to help a small group of incapacitated aged. The target group consists of elderly people who are being abused, neglected (includes self-abuse/neglect) and/or exploited by others or themselves and who have no one to assist them. It is estimated that there are about 5 percent of the over-65 age group who fall into this category and the State of Missouri has little in terms of services for them except placement in a nursing home. There are 25 million over-64 in the country and Missouri ranks 7th in the nation in this age bracket.

> It became the unhappy custom of social agencies, churches, et al., to "peddle" requests for service for this group to other social institutions as no one seemed to be able to coordinate the services needed. As a result, it was never fully known if the individual in need actually got serviced and frequently the friend, neighbor, or relatives requesting help became frustrated, discontinued interest and the aged individual was often abandoned.

The fourteenth source of support was provided by the State Human Services Departments who, in responding to the Committee questionnaire (See Appendix I of this report) confirmed the Committee's initial findings that the problem of elder abuse was increasing dramatically, that such abuse is not localized, but is occurring nationwide, and that the problem is as significant as child abuse. The State responses to the Committee's questionnaire have been tabulated and analyzed and are discussed in greater detail in Chapter IV of this report.

III. THEORIES FOR WHY ELDER ABUSE OCCURS

As is the case with most social problems, it is difficult to determine the specific cause or causes of elder abuse, particularly with the limited knowledge base that now exists. Most experts do appear to believe, however, that a major precipitating factor is family stress. Meeting the daily needs of a frail, dependent elderly relative may be an intolerable burden for family members. The resulting frustration may sometimes be expressed in violent behavior.[1]

Americans live in a violent society. In *Behind Closed Doors*, a recently published book on family violence, it was noted that the first national study of violence in American homes estimated that every other house in America is the scene of family violence at least once a year. Author Richard Gelles states:

> We have always known that America is a violent society. A war in Vietnam, a riot in Watts, a gangland slaying, a political assassination or a rape in an alley are all types of violence familiar to Americans. What is new and surprising is that the American family and the American home are perhaps as or more violent than any other single American institution or setting (with the exception of the military, and only then in time of war). Americans run the greatest risk of assault, physical injury, and even murder in their own homes by members of their own families.

That family violence occurs, in whatever form—child battering, wife beating, or elder abuse—is so shocking and repulsive that many are reluctant to believe it or understand what brings such behavior to pass. No one theory provides the entire explanation for the cause of family violence. Experts generally agree, however, that any one or a combination of any of the following factors may explain why our elders are abused by their loved ones.

A. RETALIATION

Some experts surmise that elder abuse is a form of retaliation, or revenge, in which the abuser was mistreated as a child and returns to abuse the parent. For example, in a University of Michigan study at the Institute of Geronotology, investigators hypothesized that abusers are often the "battered child grown old." Mistreated as children, they become abusive parents themselves, both of their children, and later on, of their older parent.

In some cases, the elderly are reaping what they sowed. According to a study conducted by Dr. Suzanne Steinmetz, University of Delware professor, children treated non-violently as they grow up attack their parents later on by 1 in 400; however, if a child is mistreated violently by the parent, the chance they'll attack their parents later on is 1 in 2.

Chicago psychiatrist Mitchell Messer, whose clients include adults caring for elderly parents, stated: "We find parent beatings when the parents set the example of solving problems through brutality when the children were growing up. If a if the elderly parent continues to bait their vulnerable child. The response is simply following the example his parents set."

There are often unresolved conflicts and resentments existing between the generations. Some adult children appear almost castrated emotionally from a history of parent abuse. Their reaction is to strike back. This may be compounded if the elderly parent continues to bait their vulnerable child. The response is violent aggression. Former social worker, Agnes McRoberts of Houston, in an article in *Dynamic Years*, states that battered parent cases she has seen follow a typical pattern, involving a "symbiotic relationship" in which an alcoholic daughter or son and an aging mother are mutually dependent on one another. The mother is indulgent, compulsive and clinging. She suddenly cuts off money to her adult child which triggers anger, resentment and abuse, particularly when the adult child has been drinking.

---

[1] Fowler, Jan, *Domestic Violence: Elder Abuse*, Library of Congress, Congressional Research Service, Education and Public Welfare Division, February 6, 1981, page 4.

B. VIOLENCE AS A WAY OF LIFE

Another rationale for elder abuse is thought by some to be the widespread acceptance of violence in American society, which fosters a climate in which it is acceptable to express frustration and stress in violent ways. In some families, patterns of violence exist from generation to generation, as a normal response to stress. In a study of Intergenerational Family Violence, Dr. Elizabeth Rathbone-McCuan of Washington University in St. Louis sees the family as an excellent breeding ground of violence and a social unit subject to interpersonal stresses, internal and external strains and experiences which create conflict among family members. She reported, "Since violence can and does occur within the family setting, and since the society in general holds predominantly negative attitudes toward the aged person, the likelihood of physical attack or other abuses of the aged person by family members is worthy of additional consideration."

Researchers in a Cleveland-based study[2] also believe there are family patterns of violence which continue from generation to generation: "Violence is the normative response to stress in some families, and patterns of long-term family conflict, bickering and intentional generation of negative responses can pre-exist the current abuse by many years." Also, unresolved conflict, from childhood or mid-life, can cause an elderly relative to become a burden carried with great stress and ambivalence which increases the risk of abuse.

C. LACK OF CLOSE FAMILY TIES

In some families where there is little or no closeness of a relationship between the adult children and their parents, a sudden appearance of a dependent elderly parent can precipitate stress and frustration without the love and friendship necessary to counteract the new responsibilities of the adult children. For a large part of their lives, many elderly are not able to integrate themselves with the lives of their children. Sometimes, this is due to geographical distance or sometimes emotional distance. Thus, when such an elderly person is unable to live independently they may reunite with their children after many years of separation. The elderly parent can become resented as an intruder, and abuse follows. For example, a counselor reported that a son was determined he and his wife would care for his elderly father. However, the burden of the care fell on the wife who had never gotten along with her father-in-law. She felt the pressure of caring for the older man, the pressure of caring for her own family. She began to beat the father-in-law. He was finally removed from the home, after counselors convinced the family it had to be done.

D. LACK OF FINANCIAL RESOURCES

"Under such circumstances as lack of money and the stress of dealing with a dependent older person, normal people often lash out against their elders," stated Dr. Steinmetz of the University of Delaware. The pressure and frustrations of family and financial problems is often cited by experts as a factor which drives family members to abusive behavior.

Many families caring for elderly parents or grandparents live on either fixed incomes or strict budgets during these times of increasing inflation, rising unemployment and skyrocketing fuel costs. Also, the increasing medical costs associated with the care of an older family member can often go beyond the depleted savings of the elderly parent and the penny-pinched resources of their children. The stresses associated with insufficient income combined with the inherent stress of providing daily care for an individual who requires a considerable amount of assistance with daily living tasks, can often become overwhelming and precipitate physical abuse and neglect.

Adding to an already tense financial situation is the factor that women, the primary caregivers in families, are increasingly entering the work force. Should this daughter or daughter-in-law quit her job and stay home to care for her elderly parent, thus losing her sense of freedom, independence, as well as financial reward, or should she stay at home to care full-time for the dependent parent? The dilemma is that she will be financially strapped either way. If she

---

[1] Fowler, Jan, *Domestic Violence: Elder Abuse*, Library of Congress, Congressional Reviders: Practices and Research Issues." Chronic Illness Center, Cleveland, Ohio, 1978.

works, she must find someone else to care for the parent during the day, and if she does not work she loses the additional income needed by the family, for basic necessities as well as the increased medical bills for the care of the elderly parent.

Unfortunately, this overtaxing of a family's resources is sometimes exacerbated by Federal and State government policies that limit or reduce benefits and services to elderly people when they live with their families. For example, the Federal Supplemental Security Income (SSI) program provides a minimum income floor to low-income aged, blind and disabled individuals. However, when an eligible individual is living in the household of another individual and receiving support or in-kind maintenance from that person, the monthly SSI benefit is reduced by one-third. Another example is the Medicare program, the Federal health insurance program for persons over the age of 65. The Medicare program provides home health services, but they are contingent on numerous requirements and do not cover the ongoing non-medical care and services that a dependent elderly person often needs to assist him or her to remain at home.

On the other hand, the Medicaid program, a Federal-State matching program that provides medical assistance for certain low-income persons, including the elderly, is structured to extensively subsidize nursing home care but offers less assistance to elderly individuals who wish to remain in their own homes.

Services such as homemaker and chore services, adult day care, and adult protective services are provided by the State under the social services program authorized by Title XX of the Social Security Act. This title provides federally matched funds to the States for wide variety of social services, including many services for the elderly. Eligibility for those programs, excluding adult protective services, is limited to SSI and Aid to Families with Dependent Children (AFDC) recipients and individuals and families who have incomes less than 115% of the State's median income, adjusted for family size. This criterion alone excludes many families who, despite their ineligibility, may not be able to afford these services on their own.

Many experts believe that it is this inability to obtain needed services coupled with the lack of financial resources which can build resentment and foster abusive conduct in even the most loving family.

E. Resentment of Dependency

Caring for a frail elderly parent, who requires a considerable amount of assistance can be a very draining experience. Oftentimes, the caregiver can become overwhelmed with the infringement this places on his/her own time. A child can feel trapped by the burden of caregiving at a time of anticipated independence from child-rearing. This can lead to frustration, anger and resentment, precipitating some form of abuse.

Many middle-aged family members feel resentment with the sudden intrusion of dependent parents. An example cited in a University of Michigan study[3] is a common one:

> . . . a family situation in which the grandparents either gradually or quite suddenly become dependent on their own middle-aged children who are simultaneously experiencing the dependencies of their own teenage or young adult children . . . similarly, middle-aged adults who have just emerged from the parental role with a new sense of freedom and independence, may also find themselves burdened by the dependencies of their own parents.

The resentment of having to care for their frail, bedridden, often incontinent parent, which ties them to the home pushes many to the breaking point. Often these adult children want to do the right thing, but are unable to cope with the financial and emotional stress required to do so.

Even more frustrating for the adult child can be the hopelessness and despair experienced by their elderly parent as they become more and more dependent and vulnerable. The elderly parent may begin to feel a loss of control over the basic tasks of daily living. This feeling of helplessness can result in a demanding or totally withdrawn patient. Either behavior can be intolerable for the caregiver and lead to frustration and abuse.

---

[3] Douglass, Richard, Hickey, Tom, and Noll, Catherine, "A Study of Maltreatment of the Elderly and other Vulnerable Adults," University of Michigan, Institute of Gerontology, 1980.

A number of letters which came to the attention of the Committee expressed the resentment which can result from caring for a dependent relative. For example, one individual wrote:

> We made many sacrifices for my mother—not being able to go away for week-ends and vacations when we wanted to because she could not be left alone. Fetching and running for her—taking her where she had to go, fixing the house for her—the list is endless. And all the while she occupied an apartment which was worth hundreds of dollars, for free. In the end, her lawyer gets everything—and we were abused by her because the lies she told everyone about us were believed by many.

Another echoed these sentiments:

> Here, the number of our elderly population exceeds the national average I believe; and thus, there are many aged parents and relatives being cared for by their families, presumably uncounted in any survey on the subject. When this confining situation calls for one person to put his or her own life "on hold" because it is necessary to spend all day and every day as the sole companion of a demented senile patient, the unrelieved tension is bound to take its toll on even the most loving and gentle custodian.

And, another commented:

> I think you should explore the child's side of taking care of the aging parent. The child, sometimes in their 50's or 60's also has medical problems and diminishing strength to cope with the care of aging parents on a 24-hour basis . . . I had to cope with increasing medical problems of my mother for seven years, plus my inability to work and lack of any personal life because of these demands. I experienced this over a year ago and I still feel emotionally and physically drained. While giving the care, I often pushed myself beyond my limits and this affected my personality and influenced my ability to give the type of care I would have liked.

Sadly, these individuals are not alone with respect to the resentment they feel toward the people they care for. A report, *Future Directions for Aging Policy, A Human Service Model*, issued by the Committee on Aging last year, revealed that as many as one out of every ten dependent older persons will be abused by their caregiver each year.

F. Increased Life Expectancy

Associated with dependency is the dramatic increase in life expectancy, with more people reaching age 75 and over than ever before in history. At the same time, the fertility rate has dropped considerably. This means the dependency period of old age has been extended, leaving caretakers to provide extensive home care for a longer length of time. It also means there will be fewer middle-aged adult children to care for their elderly parents and grandparents. An Institute of Gerontology study at the University of Michigan[4] stated:

> It may be that the increasing presence of the elderly and their rolelessness is a likely contributor to their own vulnerability. It is now likely that in old age, people will be dependent upon their own children or grandchildren longer than their children were dependent upon them.

G. Lack of Community Resources

According to Maggie Kuhn, convenor of the Gray Panthers—an organization designed to bridge the gap between young and old populations—even the best of parent-child relationships can deteriorate as the burden of care persists over a long period of time, as noted earlier. Those children who are financially equipped to maintain their dependent relatives in their homes oftentimes are unable to find the services in their communities to assist them to do so. Numerous witnesses have testified that few support systems currently exist in local communities for caregivers to draw upon and those that do exist are virtually unknown to the average citizen.

Work responsibility, lack of training and sensitivity[4], renders the average child helpless to meet their older relative's specific dietary and physical requirements. Many children can become overwhelmed by the emotional and financial responsibility and are simply unable to find the social and health in-home services they need. Some experts see battering of the elderly as a natural consequence of inadequate services to families caring for a frail elderly relative.

---

[4] Ibid.

H. STRESS AND OTHER LIFE CRISES

The dramatic change that can occur when a frail elderly parent moves in with a family already struggling in several areas of family relationships produces intense stress. For some elderly people, constant nursing supervision is necessary. The care of a dependent person can be physically and emotionally exhausting and a caregiver can deal with only a certain amount of stress before reaching the breaking point. According to Dr. Steinmetz, "the bottom line is that if you increase the stress on family members without adding supports to help them cope with it, you increase the likelihood of violence because a person and a family can handle only so much."

Most experts tend to agree with Dr. Steinmetz that family stress is a major precipitating factor in elder abuse. One study found that the elderly person was a significant source of stress to the family in 63 percent of the reported abuse cases.

1. History of Personal or Mental Problems.—In families where the adult child has a history of personal or pathological problems, a potential for abuse exists. In numerous cases reviewed by the Committee, mentally impaired children were responsible for abusing their parents. Family members appear to become the objects of such abusive behavior because of their proximity to the abuser. Some crises triggers the abuser, who strikes out at the nearest person or object.

2. Unemployment.—Unemployment is a major stress-producing experience for most individuals. It is even more stress-producing if unemployment occurs at middle age. Dr. Steinmetz reports that intra-family violence occurs much more frequently when the major income-producing member (generally the male-adult-husband) is unemployed. This theory has proven to be true in many cases of spouse and child abuse and appears to be a significant problem triggering elder abuse.

3. History of Alcohol and Drug Abuse.—The Committee found many instances of abuse wherein the abuser was experiencing alcohol and drug consumption problems. Consistent consumption of alcohol and drugs are readily identifiable as contributing to family violence. Because alcohol acts as a depressant, the effect seems to depress aggression inhibition systems, thus making aggressive behavior much more likely. The following is one such case reported to the Committee in which alcohol appeared to be a precipitating factor:

> A young woman and her husband separate and get a divorce. The couple was living with the husband's mother and one child of their own. When the couple separated, the husband left home while the wife and child stayed with the mother-in-law. She would beat her, cash her social security checks, and feed her like an animal. The daughter-in-law used alcohol frequently.

And, another case:

> In a drunken rage, a middle-aged man beat his 67-year-old stepmother into unconsciousness with a metal pitcher resulting in a one-month hospital stay.

I. ENVIRONMENTAL CONDITIONS

Certain environmental factors can precipitate stress which may then lead to neglectful or abusive behavior of family members, especially the frail elderly persons forced to seek assistance in the basic tasks of daily living. Quality of housing, unemployment, intra-family conflict, alcohol and drug abuse, neighborhood and crowded living conditions can by themselves or in combination with other factors encourage mistreatment of a dependent elderly person.

Such an example is found in a case study in Lee, New Hampshire in 1978 where a combination of environmental factors precipitated abuse: A 48-year-old son was found guilty of manslaughter, by beating, in the death of his 78-year-old mother. The son lived with his mother in a trailer. The mother was incontinent, unstable on her feet, and required extensive personal care. Health, living conditions and the quality of the mother-son relationship all contributed to the son's frustration, anger and finally physical violence.

IV. SURVEY OF STATE HUMAN SERVICE DEPARTMENTS

Under the present interpretation of the U.S. Constitution, the right to make and enforce criminal laws and other so-called "police powers" rest almost exclusively with the States. Accordingly, the States have the primary responsibility for protecting the rights of all their citizens, young and old alike. It is clear even from a cursory review of the literature that all States have active programs underway to protect the rights of juveniles and more recently, many States are making an effort to protect battered wives. However, it is also clear that the States have just begun to recognize the problem of elder abuse and are beginning to do something about it.

In order to learn to what extent the States have anticipated this long hidden and increasingly more serious problem, Chairman Pepper together with Congresswoman Mary Rose Oakar, a senior Member of the Committee, directed questionnaires to each of the States on July 17, 1980. The questionnaires for the most part where directed to State Human Service Departments. However, a few Sates were found to have invested authority for protective services in other agencies.

The questionnaire was warmly received by the States. The overwhelming majority of the States responding were supportive of the proposed legislation to establish Federal model mandatory reporting requirements for elder abuse which would be recommended for the consideration of the States. A few States remain undecided, none were opposed.

Most of the States were apologetic about the quality of the data they were providing to the Committee. They noted that while they recognize the growing importance of elder abuse, the topic has been given little attention in the past, in the sense that few statistics have been kept relating to abuse of adults by their loved ones and even less data is available with respect to abused senior citizens.

This section summarizes the responses received from the States. Even though the data is less than comprehensive, what emerges is a national picture of a desperate problem which only recently has tumbled from the shelf of taboos which could not be discussed in public. The results of the questionnaire reinforce the conclusion that the problem is both serious and widespread and that action must be taken immediately to deal with it.

OVERVIEW

All the States, in one way or another, noted that they had an office with responsibility to provide protective services to some segment of the adult population. As noted, many States such as Delaware, the District of Columbia, New Mexico, North Dakota, Texas, Washington and Wyoming said that they were providing such services to the needy even in the absence of authorizing legislation. For the most part, the States responded that such services were available to all those over the age of 18. However, there were a few peculiarities: Connecticut and Vermont told the Committee their protections extended only to adults over age 60. Florida, on the other hand, offers protection to those 18–64 if disabled and to those over 65 under all conditions. Wyoming protects all adults over 19, while Wisconsin sets the age at 14. Oklahoma limits its protections to adults over 65.

The Committee wanted to know if the services which were offered to adults were provided without reference to income. The answer for the most part was in the affirmative. The exceptions were as follows: Missouri and South Dakota both reported applying the Title XX income test to determine eligibility. Virginia offers optional service components free for 10 days and thereafter, the services are based on income eligibility criteria. Massachusetts and Wisconsin reported having sliding fee scales which were keyed to income. Maine has no income criteria but clients must be in the care or custody of the Department of

Human Services, at risk. New Hampshire reported providing services regardless of income when the victim is incapacitated as well as abused.

The following section describes the States' specific responses to the Committee's questionnaire.

A. BUDGET AND RESOURCES

The first section of the questionnaire asked the State Human Service Departments how much money was allotted for all protective services, for adult protective services, and for child protective services. It also asked the respondents to estimate the portion of the budget of adult protective services which went toward providing protective services to the elderly. Moreover, the States were asked for the number of State Adult Protective Service employees, their qualifications and salaries, and the salary of the chief of the Adult Protective Services office. By compiling the replies, a profile of the average State department which offers protective services has been created.

Question 1 under this section asked the States to compare as best they could what their budget was for all protective services in their State over the past two years. Most States responded with calendar figures in 1979 and 1980, although a few provided numbers on a fiscal year basis. Table I displays State budgets for all protective services for 1980. The average State budget was about $14 million. California reported spending the most at $129 million, followed by New York and Texas with $52 million and $48 million respectively. Utah reported spending the least with $835 thousand followed by Montana with $1.2 million.

Question 2 asked approximately what was the States' budget for adult protective services in the same two years. The States spending the most money in 1980 were California with $14.8 million followed by New York with $10 million and Ohio with $5 million. Several States such as Utah and South Dakota reported spending very little money and a number of others did not answer the question. The average State budget was about $1.9 million. See Table I for 1980 State budgets for adult protective services. Pennsylvania spent the highest percentage of its protective service dollars for adults, 28 percent, Nebraska and Ohio were next with 25 and 21 percent respectively.

Question 4 asked the States to provide their budgets for child protective services over the past two years. Table I, which displays State budgets for 1980, confirms that the States are spending most of their protective service monies for children. A quick glance at Table I, for example, shows that of Florida's total budget for protective services, $17.3 million went for child protective services, whereas, only about $1.2 million of Florida's budget was allocated for adult protective services although 87 percent of the adult protective service monies was relegated to the elderly. The remainder of the States reported an experience similar to the State of Florida in their allocation of protective service resources. On average, the States spend about $12.6 million for child protective services.

The picture is further clouded by the responses to question 3 which asked the States to estimate the portion of their adult protective service budget which went to the elderly. As Table II indicates, Florida's response was 87 percent in 1980 or something like $900,000 of the $1.2 million the State reported spending on adult protections. Of interest are States like Connecticut and Vermont whose laws limit jurisdiction to those over 60 and who therefore allocate about 100 percent of their monies to the elderly. Utah and Wyoming said that of the money earmarked for adult protections, some 90 percent went to the elderly. As could be expected, many States did not answer this question. Some States indicated that they spent few if any dollars specifically to provide protective services to senior citizens. Others said they could compile the data only after extensive allocation of time and resources; others said they did not have the information available; and other States said they did not have the raw data, not to mention the manpower and the know-how necessary to compile such information.

Table II applies the percentages reported by the States in answer to question 3 to the dollar amount reportedly spent to provide protective services for adults as indicated in Table I. While it is assumed that some States spent close to nothing and thus did not respond to the questions, the 32 States which did reply to this question spent from a low of $4,950 in Utah to a high of $5,088,399 in New York to provide protective services to senior citizens. The nationwide average is a very modest $679,254 per State.

It should be obvious that if every Human Service Department in the nation would compile and publish this protective service data on a uniform basis, it would be a tremendous aid to State, local and Federal policymakers when analyzing allocation of resources with respect to populations in need.

Table III shows the percentage of State protective services devoted to senior citizens in 1980 using the same 32 States (absent Massachusetts). Arizona led the list with fully 15 percent of its entire protective service budget going toward the elderly. Kentucky and Nebraska were in second and third position with 14.72 and 13.61 percent respectively. Ironically, Texas and Maine, with heavy concentrations of senior citizens, were ranked at the bottom with .35 and .45 percent of their entire protective service budgets going toward senior citizens. The nationwide average was 6.60 percent.

The obvious question is how do these figures compare with what is spent on providing protective services to children, that is, those under age 18?

As is seen in Table III, the States are spending the great majority of their protective service dollars on children. Hawaii, South Dakota, and Maine lead the list in allocating the greatest percentage of such dollars to youth with 97.18, 96.91 and 94.39 percent of their funds going to children respectively. California was the low with only 68.84 percent of their total protective service budget going to those 17 or younger. The nationwide average is 86.77 percent.

Since there are roughly only twice the number of children 18 years of age and younger as there are senior citizens, there is obviously a tremendous disparity in the funds that are committed to prevent elder abuse. As can be seen from Section I of this report and indeed, from responses received from the States themselves, the problem of elder abuse exists in epidemic proportions. The incidence of such abuse appears to be growing and few States have allocated the kind of resources they need to meet the problem.

By adding together the average figure the States spend on children, 86.77 percent, and the average they spend on senior citizens, 6.60 percent, it is apparent that the remainder, or only 6.63 percent of State protective service budgets are spent to provide services to adults between the ages of 18 and 64. This figure should be of interest to those concerned about the increasing incidence of battery between married individuals.

The next question asked the States for the total number of employees involved with adult protective services. As could be expected, many States had nothing to report. Of those States that did answer, New York topped the list with a total of 360 full-time employees and Minnesota was at the bottom claiming that one half of one full-time employee per year is allocated to adult abuse problems.

Question 6 asked for the salary of the Chief of the State Adult Protective Service Office. Alaska paid the most at $40,068 per annum plus 25.5 percent fringe benefits followed by Florida at $34,900. Once again, many States did not answer, probably because they did not have such an officer. Among those that did reply, West Virginia was the lowest with $13,416. The nationwide average was $24,500.

Asked what was the average salary for professional adult protective service workers, the States responded in a range from Alaska's $25,584 plus 25 percent benefits, down to $11,000 in Ohio. The nationwide average was about $14,000.

Question 8 asked what requirements an individual must meet before he or she can qualify as an adult protective service worker. Of the States which responded, only three States required these individuals to be licensed, Utah, Idaho, and Indiana. Some 20 required that the individuals must have good moral character. Half of the States reported requiring such workers to pass an examination. Only 15 required prior experience, and the same number required minimum training. Some two-thirds of the States require that the adult protective service workers meet minimum education requirements. Obviously, these statistics can be read to suggest that most of the States require little of the people they hire to the unusually sensitive position of providing protective services to abused adults.

B. Powers and Duties

In the second part of the questionnaire, the Committee made an effort to learn about the exact authority conferred by State statutes. The States were asked to send a copy of their laws and to send copies of any pending legislation. As could be expected, the States have greatly varying powers. Many States have virtually no authority in this area as spelled out above. However, even those States which claimed to have authority proved to have little when analyzed critically.

For example, the majority of State adult protective service divisions under the State Human Service Departments had the authority to receive complaints and investigate them. Virginia, New Mexico and Missouri, however, reported that while they could receive reports, they could not conduct follow-up investigations without the consent of the abused adult or the guardian. The same is true in the District of Columbia, but the caseworkers in the Department have been aggressive and have, in fact, gone beyond their legislative authority to help people in need.

Numerous States, such as Hawaii and South Dakota, have limited their authority to supervise the recipients of Title XX services. In some States, like Iowa and Louisiana, services must wait until there is a request from the victim or his/her guardian. Alaska, Montana and Pennsylvania also join Iowa and Louisiana as States which have so-called voluntary adult protective services available.

On the other side of the spectrum, Oklahoma, Kentucky, Nebraska, and Colorado reported having statutory authorities not only to receive complaints but to open investigations on their own as well as following up on complaints without prior consent of any party.

Some States, such as Nevada, Tennessee and New York outline their authority in very broad language. New York, for example, responded that the Department:

> "Shall provide protective services in accordance with Federal and State regulations to or for individuals without regard to income, who, because of mental or physical disfunction are unable to manage their own resources, carry out their daily living or protect themselves from neglect or hazardous situations without assistance from others and have no one available who is willing and able to assist them responsibly.

The Maine statute keys on the word "incapacitated." The Department deals only with people found to be in this state and there are elaborate guidelines to determine if individuals fall within it. Maine has the power of subpoena and access to court to enforce them. The law mandates that complaints be investigated witin 72 hours. The statute confers the power of emergency intervention as well as the power of public guardianship and/or conservatorship.

If a generalization can be drawn from a review of the authority conferred to adult protective service agencies by State law it would be that such powers appear to be more on paper than real with the exception of a few States. More discussion of this topic is found later in Section V of this report. Nevertheless, it is gratifying that 21 States and Puerto Rico and the District of Columbia reported to the Committee that they are in the process of considering the enactment of stronger or more specific elder abuse laws. (Section V provides more details).

C. ABUSES

The third section of the questionnaire was an effort to collect data on the number of elder abuse complaints received by the States over the past few years, to see if the incidence of such complaints is increasing, to compare it with the incidence of child abuse cases reported and to quantify the kinds of elder abuse by type, perpetrator, and victim.

Question 1 asked for the number of adult abuse complaints received. Half of the States responded with Florida and Washington leading the list at about 11,000 and 10,000 respectively.

Question 2 asked the States to estimate the percentage of adult abuse complaints which involved the elderly. Again, about half of the States responded. Among those who answered, the average was 60.8 percent. This is yet another indication of the growing importance of the elder abuse question.

Question 3 in this section asked for the number of child abuse cases. Washington and New York led the list in 1980 with about 50,000 complaints; Montana and North Dakota reported the lowest numbers, both around 1,200. The average for the nation was 10,957.

In question 4, the States were asked if they had recent examples of various kinds of abuses perpetrated against the elderly. All of the States responding reported having recent evidence of physical abuse of the elderly by their loved ones or guardians and all States have examples of financial abuse or exploitation. Only three States, Vermont, Montana, and Mississippi, had no recent examples of psychological abuse. Minnesota is the only State reporting no recent examples of material or financial abuse. Vermont and Nevada were the only two States who said they had no recent experience with the violation of the rights of the elderly. A number of States wrote in other kinds of abuse, including sexual abuse, self neglect, and self abuse. (See Table IV).

When asked in question 5 to give a breakdown of the number of each type of elder abuse, most States said they had insufficient data to do so. However, the national average among those who did reply is as follows: physical abuse and neglect accounts for about one-third of the cases and financial abuse for about one-quarter of the total. Psychological abuse accounts for about 15 percent more and the category of violation of rights accounts for about 9 percent more. The residual 9 percent constitutes a category of "other" abuses of which the largest number appear to be sexual abuse.

The Committee asked the States for a percentage of the elder abuse complaints which were subsequently substantiated. Once again, given the limitations of the data, with 20 States responding to this question, it appears that about 50 percent of all complaints in these States were substantiated while 30 percent were not and 20 percent were inconclusive. Many States responded that they were unable to investigate many cases for a variety of reasons.

In Question 7, the States were asked if they were of the opinion that a significant number of elder abuse cases go unreported each year. Every State with the exception of Ohio answered in the affirmative. Florida said that 50,000 cases or more probably go unreported within its boundaries each year. This compares with an estimated 9,570 cases of elder abuse which were reported to the State in 1980. Florida indicates that there were approximately 11,000 adult abuse cases reported in 1980 and that about 87 percent of its adult abuse funds went to dealing with problems of the elderly. Assuming 87 percent of the cases involved the elderly, approximately 9,570 would have related to seniors. Also, in Question 7, the States were asked what number of cases of elder abuse would they say went unreported in 1980.

With the information provided to the Committee by the States on the incidence of elder abuse cases reported and unreported annually, and on the incidence of child abuse cases reported annually, a comparison of the probable incidence of abuse among the two segments of the population was derived. By contrast with the data on elder abuse, most of the States submitted fairly specific information as to the incidence of child abuse cases. However, because the Committee failed to ask the States to provide data on the estimated unreported incidence of child abuse, these figures were derived from the national estimate that 3.4 per 1,000 child abuse cases are reported and an additional 7.1 per 1,000 cases go unreported, as estimated by the Westat, Inc. Report on "Recognition and Reporting of Child Maltreatment: Findings From the National Study of the Incidence and Severity of Child Abuse and Neglect," prepared for the National Center on Child Abuse and Neglect, Department of Health and Human Services. In other words, of total estimated cases, only about one-third child abuse cases are reported, while in adult abuse, an estimated one-sixth is reported.

To begin with, there are about 62 million individuals under the age of 18 in the United States, or 27.9 percent of the total population according to the U.S. Census Bureau. By contrast, there are 25 million senior citizens who make up 11.2 percent of the population. Since there are 2½ times as many young people as senior citizens, it would seem logical that there would be more than double the amount of abuse cases. This turns out to be about what the data suggests.

The questionnaire asked the States to provide actual and estimated elder abuse cases in each instance. To make a comparison, the Committee chose the ten States which provided the most complete data. These States included Connecticut, Florida, Georgia, Iowa, Nebraska, Oklahoma, South Carolina, Tennessee, Vermont, and Washington.

These States had approximately 10,000,000 children under 18 and 4,340,500 individuals over the age of 65 in 1980. The ten selected States reported 23,869 actual cases of elder abuse in 1979 and estimated that an additional 146,182 cases of such abuse went unreported. In other words, the States which had such data said that roughly one out of every six cases of elder abuse goes reported. These same States reported 227,813 actual cases of child abuse involving individuals under the age of 18 in 1979 while estimating that about 455,665 cases of this same nature went unreported. In other words, roughly two-thirds of all child abuse cases are not reported. The combined total of reported and unreported elder abuse cases was 170,051 and the combined total of reported and unreported child abuse cases was 683,478.

Even this data, as straightforward as it seems, has its problems. For example, States exhibited some confusion over the definition of the word "case." Some States counted any complaint as a case. Others appeared to count only those where a file was opened and an investigation was underway. Other States pointed out that they counted separate episodes involving the same individual as a case. Some reported the number of children served.

With these limitations understood, the Committee divided the number of reported and estimated unreported elder abuse cases in these selected ten States (170,051) by the number of senior citizens in the States (4,340,500). The conclusion is that approximately 4 percent of the elderly in these States may be victims of some form of elder abuse from moderate to severe. Dividing the total number of reported and estimated child abuse cases by the total population in the selected States (683,478 divided by 10 million), the Committee estimates that approximately 6.8 percent of the under 18 population are similarly abused.

Assuming that these figures can be applied nationally, it would appear that the incidence of elder abuse is not as great as that of child abuse but the level is still significant. If it is true that 4 percent of the elderly are victims of such abuse as these figures suggest, the consequences are staggering. It must be recalled, for example, that approximately 5 percent of the senior citizen population is housed in American nursing homes on any given day although one out of 20 will spend some time in a long-term care facility prior to their death. Four percent can be translated to suggest that one out of every 25 or roughly one million older Americans may be victims of such abuse each year. This figure tends to reinforce a number of Statewide studies conducted in other States, which have put the estimate at one million cases a year.

Assuming the accuracy of the four percent figure and the fact that numerically there are four times as many child abuse cases as adult abuse cases (170,051 vs. 683,478 in the ten States), it would seem that the States should be devoting at least one-fourth if not more of their protective service budgets to senior citizen abuses. Measured another way, since there are 2½ times the number of children as senior adults, the States should be spending 40% of their protective service budget for senior citizens. Unfortunately, as pointed out in this section, the States are spending the great bulk of their limited funds to combat child abuse. As noted in Table III, the States on the average committed only 6.60 percent of their protective service budgets to the elderly, with 86.77 percent going to children and the remainder being spent on adults age 18 to 64.

These figures outline the disparity that exists and suggests the need for the States either to increase their funding or to reallocate their resources.

When asked in question 8 for the source of their complaints, the States gave widely varying answers. Some States said family members of the victims were the prime source of complaints, others said hospitals or clinics, still others stressed police, lawyers or public service agencies. It is apparent the data is too incomplete to be able to draw definitive conclusions beyond saying that all of the above play a significant role in bringing examples of elder abuse to the attention of State Protective Service Departments.

Asked if their State had standardized forms for reporting elder abuse, 23 States said yes. (See Table V). Asked for the average time it took them to resolve elder abuse complaints, the States gave widely varying answers. Four States said one week and the same number said up to a year. The greatest number of those replying said two to six months on the average.

The next series of questions was designed to identify the abusers and the abused as well as to isolate the underlying causes.

In sifting the admittedly incomplete data received from the States, one pattern emerges. When only related individuals are tallied, the consensus is that the son of the victim is the most likely abuser in about 21 percent of all instances followed by the daughter of the victim in about 17 percent of all cases. Third in line was the spouse of the elderly person when acting in a caregiving role, with the male spouse slightly more likely to be the abuser than the abused. Other relatives such as daughter-in-laws and son-in-laws and grandchildren followed in descending order of frequency although most of the States also mentioned nieces, nephews, siblings, and cousins as prominent potential abusers. Unrelated caretakers who live with the elderly including those appointed as guardians or conservators were also listed as abusers of the elderly.

The most common root cause for elder abuse is stress, accounting for about 36 percent of all cases, reported the States. Psychological problems is next with 24 percent, followed by excessive use of alcohol, revenge, illness, and poverty, with differing ethnic beliefs also being mentioned.

The questionnaire completed by the District of Columbia, however, provided this insight:

> In almost all cases, multiple factors can be discerned as the causes of abuse. Consequently, our figures exceed 100 percent. Physical abuse correlates highly with stress and psychological problems (ranging from low self-esteem to psychosis) as well as alcoholism and drug abuse by the abuser.

The final question asked in this section was: Would you say the incidence of elder abuse is increasing? Only seven States said no. They were: Hawaii, Illinois, Indiana, Nevada, New Mexico, Rhode Island and Wyoming. (See Table VI.) Several States noted that public awareness has increased recently. They said this inevitably leads to new protective service programs by the States. The larger and more efficient the State program, the greater the number of abuses that will be found, contended these States. This may be true, however, most of the States said outright that the absolute number of elder abuse incidents was increasing dramatically.

The next section of the questionnaire attempted to learn what methods of intervention the States employed and found effective in elder abuse cases.

D. INTERVENTION

In tabulating the questionnaires, the Committee learned that slightly over half of the States have specific written instructions or procedures concerning intervention when elder abuse is found to have occurred. (See Table VII.)

Asked what was the most common course of action, the States said to call a law enforcement officer or to relocate the individual in a different setting giving them the needed supportive services. Ironically, the States said the methods most used were the least effective. Asked what was the most effective, the States said counseling and provision of services. While these methods are used they have not been used with the frequency of other interventions. (See Table VIII.)

Asked what was the greatest hindrance to their ability to help the abused elderly, 63 percent of the States said lack of appropriate statutory authority. Many cited their specific lack of authority to begin investigations unless requested to do so by the abused or their family—which often means the abuser. Obviously, this provides the protective service worker with a classic Catch 22 situation. Cited next most often by the States was the lack of properly trained staff and other resources. (Table IX.)

When asked what could be done to improve things, the States again said that new statutory authority was a must. (Table X.)

Asked about the need to increase public awareness, the States said this was a good idea, concluding that one-third of the public is generally "unaware" of the issue. No State said it felt the public was "very aware" of the issue while the majority of the States said they felt the public was "moderately aware" of the problem.

E. STATE AND FEDERAL REGULATIONS

The final section of the questionnaire asked the States whether their statutes require the mandatory reporting of elder abuse cases; whether they thought the needs of the elderly were being met through existing law and regulations; whether they would favor Federal legislation to establish model mandatory reporting laws, and finally, whether they would support H.R. 7551 (Reintroduced as H.R. 769 in the 97th Congress), as introduced in the 96th Congress, otherwise known as the Prevention, Identification and Treatment of Adult Abuse Act of 1980.

Only 16 States indicated that their current State law requires the mandatory reporting of elder abuse cases (See Section V). Kansas and Massachusetts have laws which require such reporting only if it takes place in nursing homes. South Carolina has a "failure to report" law which carries a penalty of six months in jail and/or $1,000 fine for persons found not to have reported a case. The South Carolina law also provides for legal immunity as well as anonymity for the reporter if that party so desires. Thus, a person with information merely needs to make an anonymous call or send an unsigned letter to the Protective Service Agency in order to trigger a full investigation. Several States commented that this kind of mandatory reporting law is crucial to alleviating the problem of elder abuse which involves family members who quite often keep a case from coming to the attention of the authorities.

Asked to what extent the elder abuse problems were solved in their States, 35 percent selected the word "occasionally"; 19 percent more said they were simply unsure how often the needs were being met; no State said the needs of the elderly were always being met; a few did not respond and the remainder chose the word "frequently" to describe the response in their States.

The final two questions were posed to determine the State's feeling about proposed Federal legislation to establish model mandatory reporting laws. The overwhelming majority of the States, fully 83 percent, reported that they were in favor of such legislation. Only seven States reported they were not in favor, including: Alaska, Connecticut, New York, Oklahoma, South Dakota, Utah and Washington. (See Section V) The States which said no raised questions about who should be required to report incidents of elder abuse. They suggested that some categories could be easily agreed upon such as physicians, social workers and law enforcement officials but others such as private citizens unrelated to the abused, town officials, outreach workers, local welfare workers, the clergy, etc., could themselves face criminal sanctions. Other States cast these concerns aside by spelling out that similar fears had been raised but that their laws are seemingly working well.

With respect to the support of H.R. 7551, fully 75 percent of the States responded in the affirmative with 25 percent undecided. Interestingly, no State said it was opposed. (See Section V). Those who were undecided echoed the sentiments of North Dakota which said: "To implement the legislation (our State) would need an allocation of approximately $300,000 per year and I can't imagine an appropriation that size passing Congress."

In summary, it is clear that elder abuse is a significant problem of growing importance to the State Human Service Departments. It seems just as clear that State statutes are, with singular exceptions, inadequate to fully meet the needs of the elderly. It is also apparent that States are concentrating most of their funds and resources in providing protective services to children.

TABLE I

1. What is the budget for all protective services in your State this year?

2. Approximately what was the budget for adult protective services provided by the Department this year?

3. Approximately what was the budget for child protective services provided by the Department this year?

State	1980 protective services budget	1980 adult protective services budget	1980 child protective services budget
Alabama	$14,558,889	$1,149,541	$13,409,348
Alaska	15,541,000	3,052,900	12,531,400
Arizona	4,764,619	925,000	3,668,192
Arkansas	1,808,000	108,000	1,700,000
California	129,124,251	14,875,245	88,886,541
Colorado	13,333,978	1,307,729	12,026,249
Connecticut			
Delaware			
Florida	18,551,166	1,194,268	17,356,898
Georgia	10,125,011	1,764,288	8,360,723
Hawaii	2,139,800	60,360	2,079,500
Idaho	3,291,543	845,051	2,446,492
Illinois			
Indiana	15,524,000	3,839,000	11,685,000
Iowa	7,303,316	382,927	6,920,389
Kansas			
Kentucky	5,999,764	1,358,799	4,640,965
Louisiana	8,414,349		
Maine	2,867,461	160,769	2,706,692
Maryland	9,105,039	800,000	8,305,039
Massachusetts		2,360,000	12,137,000
Michigan	16,822,037	1,169,637	15,652,400
Minnesota	26,282,000	2,628,837	23,653,173
Mississippi			
Missouri			47,000,000
Montana	1,284,279	86,646	1,197,633
Nebraska	2,453,945	629,958	1,823,987
Nevada			
New Hampshire			
New Jersey	11,075,664	2,611,841	8,463,823
New Mexico	1,902,031	201,605	1,702,426
New York	52,796,798	10,176,798	42,620,000
North Carolina	3,400,721	400,721	3,000,000
North Dakota			
Ohio	23,000,000	5,263,512	17,186,202
Oklahoma	11,000,000	663,000	10,337,000
Oregon			
Pennsylvania	18,641,352	5,141,406	8,690,831
Rhode Island			
South Carolina	6,462,378	971,653	5,490,725
South Dakota	1,335,579	41,287	1,294,292
Tennessee	9,540,966	1,683,087	7,857,879
Texas	48,230,190	2,795,138	45,435,052
Utah	835,104	5,500	662,829
Vermont			
Virginia	9,472,242	1,377,623	8,095,219
Washington	4,801,057		
West Virginia	3,943,158	573,919	3,369,239
Wisconsin			
Wyoming	1,755,124	225,718	1,529,706
District of Columbia	2,408,700	190,000	2,218,700
Puerto Rico			
Average per State	14,051,230	1,972,808	12,598,412

Note: The States of Minnesota and Tennessee did not have 1980 figures available and thus reported 1979 budget figures.

TABLE II

3. Can you estimate what portion of your budget for adult protective services went toward providing protective services to the edlerly in your State this year?

State	1980 adult protective services budget	Percent of adult protective services budget toward elderly	Aggregate amounts spent for protective services to elderly
Alabama	$1,149,541	80.0	$919,632
Alaska	3,052,900	16.0	488,464
Arizona	925,000	80.0	740,000
Arkansas	108,000	60.0	64,800
California	14,875,245		
Colorado	1,307,729	52.0	680,019
Connecticut			
Delaware			
Florida	1,194,268	87.0	1,039,013
Georgia	1,764,288	30.0	529,286
Hawaii	60,300		
Idaho	845,051	6.0	50,703
Illinois			
Indiana	3,839,000		
Iowa	382,927	55.0	210,610
Kansas			
Kentucky	1,358,799	65.0	883,219
Louisiana			
Maine	160,769	8.0	12,862
Maryland	800,000	60.0	480,000
Massachusetts	2,360,000	51.0	1,203,600
Michigan	1,169,637	56.0	654,997
Minnesota	2,628,837	85.0	2,234,511
Mississippi			
Missouri			
Montana	86,646	85.0	73,649
Nebraska	629,958	53.0	333,878
Nevada			
New Hampshire			
New Jersey	2,611,841	52.0	1,358,157
New Mexico	201,605	84.0	169,348
New York	10,176,798	50.0	5,088,399
North Carolina	400,721	65.0	260,469
North Dakota			
Ohio	5,263,512	3.0	157,905
Oklahoma	663,000	65.0	430,950
Oregon			
Pennsylvania	5,141,406		
Rhode Island			
South Carolina	971,653	60.0	582,992
South Dakota	41,287	32.0	13,212
Tennessee	1,683,087	70.0	1,178,161
Texas	2,795,138	6.0	167,708
Utah	5,500	90.0	4,950
Vermont			
Virginia	1,377,023	75.0	1,032,767
Washington			
West Virginia	573,919	60.0	344,351
Wisconsin			
Wyoming	225,718	90.0	203,146
District of Columbia	190,000	76.0	144,400
Puerto Rico			
Average per State	1,972,808	56.5	679,254

TABLE III

State	Aggregate amount spent for protective services to elderly, 1980	Percent of total protective services budget to elderly	Child protective services budget 1980	Percent of total protective services budget to children
Alabama	$919, 632	6. 32	$13, 409, 348	92. 10
Alaska	488, 464	3. 14	12, 531, 400	80. 63
Arizona	740, 000	15. 53	3, 668, 192	76. 99
Arkansas	64, 800	3. 58	1, 700, 000	94. 03
California			88, 886, 541	68. 84
Colorado	680, 019	5. 10	12, 026, 249	90. 19
Connecticut				
Delaware				
Florida	1, 039, 013	5. 60	17, 356, 898	93. 56
Georgia	529, 286	5. 23	8, 360, 723	82. 57
Hawaii			2, 079, 500	97. 18
Idaho	50, 703	1. 54	2, 446, 492	74. 33
Illinois				
Indiana			11, 685, 000	
Iowa	210, 610	2. 88	6, 920, 389	94. 76
Kansas				
Kentucky	883, 219	14. 72	4, 640, 965	77. 35
Louisiana				
Maine	12, 862	. 45	2, 706, 692	94. 39
Maryland	480, 000	5. 27	8, 305, 039	91. 21
Massachusetts	1, 203, 600		12, 137, 000	
Michigan	654, 997	3. 89	15, 652, 400	93. 05
Minnesota	2, 234, 511	8. 50	23, 653, 173	89. 99
Mississippi				
Missouri			47, 000, 000	
Montana	73, 649	5. 73	1, 197, 633	93. 27
Nebraska	333, 878	13. 61	1, 823, 987	74. 33
Nevada				
New Hampshire				
New Jersey	1, 358, 157	12, 26	8, 463, 823	76. 42
New Mexico	169, 348	8. 90	1, 702, 426	89. 50
New York	5, 088, 399	9. 64	42, 620, 000	80. 72
North Carolina	260, 469	7. 66	3, 000, 000	88. 22
North Dakota				
Ohio	157, 905	. 69	17, 186, 202	74. 72
Oklahoma	430, 950	3. 92	10, 337, 000	93. 97
Oregon				
Pennsylvania			8, 690, 831	
Rhode Island				
South Carolina	582, 992	9. 02	5, 490, 725	84. 96
South Dakota	13, 212	. 99	1, 294. 292	96. 91
Tennessee	1, 178, 161	12, 35	7, 857, 879	82. 36
Texas	167, 708	. 35	45, 435, 052	94. 20
Utah	4. 950	. 59	662, 829	79. 37
Vermont				
Virginia	1, 032, 767	10. 90	8, 095, 219	85. 46
Washington				
West Virginia	344, 351	8. 73	3, 369, 239	85. 44
Wisconsin				
Wyoming	203, 146	11. 57	1, 529, 406	87. 14
District of Columbia	144, 400	5. 99	2, 218, 700	92. 11
Puerto Rico				
Average per State	679, 254	6. 60	14, 598, 412	86. 77

TABLE IV

III. 4. Experts have indicated that many elderly are abused by their children, relatives or caretakers in obvious as well as subtle ways. The following section of this questionnaire is to ask if you have ever received complaints of any of the following practices:

State	Physical abuse	Psychological abuse	Material or financial abuse	Violation of rights	Other
Alabama	X	X	X	X	
Alaska	X	X	X	X	
Arizona	X	X	X	X	
Arkansas	X	X	X	X	
California	X	X	X	X	
Colorado	X	X	X	X	
Connecticut	X	X	X	X	
Delaware					
Florida	X	X	X	X	
Georgia	X	X	X	X	Sexual abuse.
Hawaii	X	X	X	X	
Idaho	X	X	X	X	Self-neglect.
Illinois	X	X	X	X	
Indiana	X	X	X	X	
Iowa	X	X	X	X	
Kansas	X	X	X	X	
Kentucky	X	X	X	X	
Louisiana	X	X	X	X	Exploitation.
Maine	X	X	X	X	
Maryland	X	X	X	X	
Massachusetts	X	X	X	X	
Michigan	X	X	X	X	
Minnesota	X	X	No	X	
Mississippi	X	No	X	X	
Missouri	X	X	X	X	
Montana	X	No	X	X	
Nebraksa	X	X	X	X	
Nevada	X	X	X	No	Self-neglect.
New Hampshire	X	X	X	X	Hazardous living conditions.
New Jersey	X	X	X	X	
New Mexico	X	X	X	X	
New York	X	X	X	X	
North Carolina	X	X	X	X	Self-neglect.
North Dakota					
Ohio					
Oklahoma	X	X	X	X	
Oregon					
Pennsylvania	X	X	X	X	
Rhode Island	X	X	X	X	
South Carolina	X	X	X	X	
South Dakota	X	X	X	X	
Tennessee	X	X	X	X	Self-neglect.
Texas	X	X	X	X	
Utah	X	X	X	X	
Vermont	X	No	X	No	
Virginia	X	X	X	X	
Washington	X	X	X	X	
West Virginia	X	X	X	X	
Wisconsin	X	X	X	X	
Wyoming	X	X	X	X	Self-abuse.
District of Columbia	X	X	X	X	Benign neglect.
Puerto Rico					

TABLE V

III. 11. Does your Department have standardized forms for reporting elder abuse?

State	Yes	No
Alabama	X	
Alaska		X
Arizona		
Arkansas	X	
California		X
Colorado		X
Connecticut	X	
Delaware		
Florida	X	
Georgia	X	
Hawaii		X
Idaho		X
Illinois		
Indiana	X	
Iowa		X
Kansas	X	
Kentucky	X	
Louisiana		X
Maine		X
Maryland		
Massachusetts	X	
Michigan		X
Minnesota		X
Mississippi		X
Missouri		X
Montana		X
Nebraska	X	
Nevada	X	
New Hampshire	X	
New Jersey	X	
New Mexico		X
New York		X
North Carolina	X	
North Dakota		X
Ohio		X
Oklahoma	X	
Oregon		X
Pennsylvania		X
Rhode Island	X	
South Carolina	X	
South Dakota		X
Tennessee	X	
Texas		
Utah	X	
Vermont	X	
Virginia	X	
Washington		X
West Virginia	X	
Wisconsin		X
Wyoming		X
District of Columbia		X
Puerto Rico		
Total	23	24

TABLE VI

III. 10. Would you say the incidence of elder abuse is increasing?

State	Yes	N
Alabama	X	
Alaska	X	
Arizona	X	
Arkansas	X	
California		
Colorado	X	
Connecticut	X	
Delaware		
Florida	X	
Georgia	X	
Hawaii		X
Idaho	X	
Illinois		X
Indiana		X
Iowa	X	
Kansas	X	
Kentucky	X	
Louisiana	X	
Maine	X	
Maryland	X	
Massachusetts		
Michigan	X	
Minnesota	X	
Mississippi	X	
Missouri	X	
Montana	X	
Nebraska	X	
Nevada		X
New Hampshire		
New Jersey	X	
New Mexico		X
New York	X	
North Carolina	X	
North Dakota		
Ohio		
Oklahoma	X	
Oregon		
Pennsylvania	X	
Rhode Island		X
South Carolina	X	
South Dakota	X	
Tennessee		
Texas	X	
Utah	X	
Vermont	X	
Virginia	X	
Washington	X	
West Virginia	X	
Wisconsin		
Wyoming		X
District of Columbia	X	
Puerto Rico		
Total	35	7

Note: The following States indicated that the awareness of elder abuse is increasing: Kansas, Maine, Maryland, Minnesota, New York, and Vermont.

TABLE VII

IV. 3. Does your agency have written instructions or procedures concerning intervention?

State	Yes	No
Alabama	×	
Alaska		×
Arizona	×	
Arkansas	×	
California		
Colorado		×
Connecticut	×	
Delaware		
Florida		×
Georgia		
Hawaii	×	
Idaho		×
Illinois		×
Indiana	×	
Iowa	×	
Kansas		
Kentucky	×	
Louisiana	×	
Maine		
Maryland		
Massachusetts	×	
Michigan	×	
Minnesota		×
Mississippi		×
Missouri		×
Montana	×	
Nebraska	×	
Nevada	×	
New Hampshire	×	
New Jersey	×	
New Mexico	×	
New York	×	
North Carolina	×	
North Dakota		
Ohio		×
Oklahoma	×	
Oregon		
Pennsylvania		×
Rhode Island		
South Carolina	×	
South Dakota		×
Tennessee	×	
Texas	×	
Utah	×	
Vermont		
Virginia	×	
Washington	×	
West Virginia	×	
Wisconsin		×
Wyoming		×
District of Columbia		×
Puerto Rico		
Total	27	14

Note: New Jersey has written instructions for intervention only for rooming and boarding home residents.

TABLE VIII

IV. 2. What is the most effective means of intervention, in your opinion?

State	
Alabama	Family counseling.
Alaska	
Arizona	Crisis intervention with supportive services, i.e., shelter.
Arkansas	Short-term protective custody.
California	Relocation, financial and legal services.
Colorado	Counseling.
Connecticut	
Delaware	
Florida	Multi-disciplined crisis team approach.
Georgia	Multi-disciplined crisis team approach.
Hawaii	Counseling with supportive services.
Idaho	Counseling and relocation.
Illinois	Treatment and counseling of individual and family plus legal action.
Indiana	Counseling.
Iowa	Legally mandated intervention.
Kansas	
Kentucky	Provision of in-home services, relocation. medical services.
Louisiana	Mobilize community resources.
Maine	
Maryland	Counseling, temporary relocation.
Massachusetts	
Michigan	Provision of services.
Minnesota	
Mississippi	
Missouri	
Montana	Provision of services (voluntary).
Nebraska	Counseling.
Nevada	Multi-disciplined crisis team approach.
New Hampshire	Provision of services, utilizing family members/significant others.
New Jersey	Counseling, relocation, linkage and provision of services.
New Mexico	Provision of in-home services involving relatives.
New York	
North Carolina	Counseling and provision of services.
North Dakota	
Ohio	Investigation.
Oklahoma	Utilizing family members and significant others.
Oregon	
Pennsylvania	Counseling and provision of services.
Rhode Island	
South Carolina	Live-in caretaker/homemaker or relocation.
South Dakota	Utilizing family members.
Tennessee	Counseling.
Texas	Intervention and provision of services.
Utah	Counseling and provision of services.
Vermont	
Virginia	Counseling.
Washington	Provision of services.
West Virginia	Counseling.
Wisconsin	
Wyoming	Personal contact by a social service agency.
District of Columbia	Counseling and provision of services.
Puerto Rico	

TABLE IX

IV. 4. What barriers make if difficult for you to provide assistance to victims of suspected or substantiated abuse?

State—Lack of:	
Alabama	Staff and resources.
Alaska	Statutory authority to provide assistance.
Arizona	Denial on the victims part, lack of adequate resources.
Arkansas	Prosecution of offenders.
California	Statutory authority.
Colorado	Staff and statutory authority.
Connecticut	Resources, staff.
Delaware	
Florida	Staff (especially 24-hour on call), resources for support services.
Georgia	Emergency shelters, statutory authority.
Hawaii	Statutory authority; resources.
Idaho	Statutory authority.
Illinois	Obtaining factual information.
Indiana	Cohesive agency with authority; too much red tape.
Iowa	Statutory authority.
Kansas	
Kentucky	Staff; sufficient support from judicial system.
Louisiana	Resources; statutory authority to intervene in involuntary cases).
Maine	
Maryland	Statutory authority.
Massachusetts	
Michigan	Resources; statutory authority to intervene in involuntary cases.
Minnesota	Statutory authority.
Mississippi	Statutory authority.
Missouri	Access to victims; statutory authority.
Montana	Statutory authority.
Nebraska	Statutory authority (especially to remove victim to safe situation).
Nevada	Finances.
New Hampshire	Staff and public education; guardianship law too complex.
New Jersey	Funding, statutory authority, legal mechanism for emergency intervention.
New Mexico	Resources to provide supportive services.
New York	Statutory authority to intervene in involuntary cases.
North Carolina	Public awareness of adult protective service laws.
North Dakota	Statutory authority.
Ohio	Statutory authority; finances.
Oklahoma	Community resources.
Oregon	
Pennsylvania	Statutory authority; authority to intervene in involuntary cases.
Rhode Island	
South Carolina	Emergency shelters; funds; training of social workers.
South Dakota	Statutory authority to intervene in involuntary cases.
Tennessee	Resources.
Texas	Statutory authority to intervene in involuntary cases.
Utah	Agency cooperation.
Vermont	

TABLE IX—Continued

State—Lack of:	
Virginia	Statutory authority to effect change.
Washington	Staff recognition of problems and programs.
West Virginia	Statutory authority; emergency shelters.
Wisconsin	
Wyoming	Statutory authority to investigate/intervene.
District of Columbia	Statutory authority to investigate/intervene.
Puerto Rico	

TABLE X

IV. 5. What must be done to make it possible for you to provide assistance to victims of suspect or substantiated abuse?

State	
Alabama	More emergency shelters; more available approved foster homes.
Alaska	Statutory authority to intervene.
Arizona	Development of emergency shelters; preventive and supportive services.
Arkansas	Staff increase; funding; prosecuting staff.
California	Prompt investigation.
Colorado	Statutory authority; funding.
Connecticut	Assistance is already provided.
Delaware	
Florida	Public education; initiation of reporting must be increased.
Georgia	Funding; community based services; ability to respond to emergency cases.
Hawaii	Establish resources (emergency shelters); statutory authority.
Idaho	Statutory authority; funding; more specific program.
Illinois	Non-public awareness of problems, including information referral for help.
Indiana	Statutory authority.
Iowa	Statutory authority.
Kansas	
Kentucky	Public support, sufficient staff, support from court system.
Louisiana	Staff increase; public education and support; court support.
Maine	Statutory authority.
Maryland	Mandatory reporting laws.
Massachusetts	
Michigan	Public support; statutory authority; court support; victim coop.
Minnesota	
Mississippi	Statutory authority.
Missouri	Consent of victim or guardian if victim is incompetent.
Montana	Revoke current guardianship laws.
Nebraska	Statutory authority for involuntary cases; funding; emergency shelters; public education.
Nevada	
New Hampshire	Improve statutes, especially re: mandatory reporting, identification of problem.
New Jersey	Statutory authority; funding.
New Mexico	Statutory authority to intervene.
New York	Statutory authority to intervene in involuntary cases; designate agency.
North Carolina	Funding; public education; services; training staff.

TABLE X—Continued

State	
North Dakota	Statutory authority; funding.
Ohio	Statutory authority; funding.
Oklahoma	Local resources (guardianship/conservatorship).
Oregon	
Pennsylvania	Funding; emergency shelters; worker protection.
Rhode Island	
South Carolina	Funding.
South Dakota	Statutory authority.
Tennessee	Alternatives to aging institutions.
Texas	Statutory authority to investigate.
Utah	Public awareness, cooperation and participation.
Vermont	
Virginia	Public awareness to increase reportings.
Washington	Staff and training of staff.
West Virginia	Client must consent to aid.
Wisconsin	
Wyoming	State adult abuse law must be enacted.
District of Columbia	Statutory authority to intervene in involuntary cases.
Puerto Rico	

V. A SURVEY OF STATES STATUTES AND EFFECTIVENESS OF STATE EFFORTS

The logical question to pose at this point is "What are the States doing about abuse of our elderly?" In order to find the answer to this question, the Committee formulated a survey, discussed briefly in Chapter IV of this report, a section of which seeks to determine whether the States have enacted laws providing protective services for adults; whether existing State statutes require the mandatory reporting of adult abuse cases; whether the States are considering legislation to provide for adult protective services and for the mandatory reporting of such abuse; whether the States would favor Federal legislation to establish a model mandatory reporting law; and whether the States would favor the passage of H.R. 7551((H.R. 769 in the 97th Congress), also referred to as the "Prevention, Identification and Treatment of Elder Abuse Act."

Before discussing the responses to the Committee questionnaire, it must be pointed out that adult protective service laws vary tremendously in scope. There is no clear guideline establishing what must be contained in a statute, or statutes, before a State can say it has an "adult protective service law." [1] For example, some States have laws authorizing the provision of services to abused adults, but do not require that abuse cases be reported. Other States with adult protective service laws require the reporting of abuse, but do not provide for the delivery of services after the abuse has been cited. In reading this section of the report, therefore, it should be kept in mind that there is little uniformity with regard to the manner in which the States have chosen to approach this issue.

The responses to the questionnaire relating to State activities to protect abused elders have been tabulated and the results appear in Table XI. A list of the agencies in each State which are responsible for dealing with elder abuse is provided in Appendix VIII. What is presented is a very mixed picture but it is evident that the States have just begun to recognize the growing importance of this issue. Only one State reported having an adult protective service law in place prior to 1973. The remainder of the State laws were passed after 1973. The majority of the laws were passed in the last five years.

As indicated in Table XI, 26 States, about half, have what they consider to be an adult protective service law.

Different States, it should be noted, protect different individuals. Kansas and Massachusetts, for example, limit the provision of services to people in nursing homes or in medical facilities operated by the State or Federal government. Other States provide protective services only on the basis of age or physical condition. For example, Connecticut, Missouri, Vermont and Virginia provide protective services only to adults over the age of 60. Montana and Oklahoma protect those 65 years of age and over and the physically impaired between the ages of 18 and 65. Although Indiana does not have an adult protective service law, it will provide services to those over the age of 55. The rest of the States provide services to those 18 and over.

The Committee found that many of the States which do not have laws are providing protection services on a voluntary basis for adults under funds they receive under Title XX of Social Security. These States include Alaska, California, Colorado, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Mississippi, Nevada, New Jersey, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas and the District of Columbia.

Only Delaware does not have an adult protective service law or mandatory reporting provisions, and does not provide services for abused adults with the Title XX funds it receives. But Delaware is aware of the problem and is anxious to enact needed legislation. The Delaware Department of Health and Social Services reported to the Committee:

---

[1] The Senate Special Committee on Aging also found this to be true after reviewing the responses they received from the States on a similar survey they conducted relating to adult protective services. The findings of the Senate survey are found in *Elder Abuse*, Joint Hearing before the Special Committee on Aging and the Select Committee on Aging, 96th Congress, Washington, D.C., June 11, 1980, page 95.

> Delaware does not have an Adult Protective Services Law, and thus we have no answers for your questionnaire. A bill was drafted by the Department of Health and Social Services for this past session of the General Assembly. It was introduced but was not passed. One of the Department's priorities for the next legislative year will be to have the attached bill reintroduced and hopefully passed.
>
> Delaware does have an Office of Public Guardian under the Court of Chancery. This office has documented the need for an Adult Protective Services Law and a unit within the Department. It is the hope of this administration that this law will be passed.

As Table XI indicates, only 16 of the 26 States with adult protective service laws, Alabama, Arkansas, Connecticut, Florida, Kentucky, Minnesota, Missouri, Nebraska, New Hampshire, North Carolina, Oklahoma, South Carolina, Tennessee, Utah, Vermont and Virginia, indicated that they also require the mandatory reporting of elder abuse cases. However, there is little consistency among these States as to whom is required to report such abuse and what penalties will apply when they fail to do so. For example, whereas Alabama requires only medical doctors, osteopaths, chiropractors and other practitioners of the healing arts to report and imposes a $500 fine or 6-months in jail for the failure to report suspected abuse, the State of South Carolina requires numerous individuals to report suspected abuse, including physicians, nurses, dentists, optometrists, medical examiners, coroners or any other medical, mental health or allied health professional, Christian Scientist practitioner, religious healer, school teacher, counsellor, psychologist, mental health or mental retardation specialist, social and public assistance worker, or law enforcement officer, and for failure to report, the State of South Carolina imposes a penalty of six months in jail and/or a $1,000 fine.

On the other hand, 10 States have adult protective service laws enacted, but do not require individuals who suspect abuse has occurred to report the incident. These ten States include Arizona, Kansas, Maine, Maryland, Massachusetts, Michigan, Montana, New York, Rhode Island, and Wisconsin.

Of the States (including the District of Columbia and Puerto Rico) without adult protective service bills and/or mandatory reporting requirements, 20 have sponsored bills in their State legislatures including California, Colorado, Delaware, Georgia, Maine, Massachusetts, Michigan, Mississippi, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Washington, West Virginia, and Wyoming. Three States, Minnesota, Missouri, and Virginia, all of which have adult protective service statutes and mandatory reporting requirements, have introduced additional measures relating to adult abuse.

Only 10 States, Alaska, Hawaii, Idaho, Illinois, Indiana, Iowa, Louisiana, Nevada, South Dakota, and Texas do not have adult protective service statutes or mandatory reporting requirements, nor any legislation pending consideration before their State legislatures.

Aside from determining what the States are doing with respect to protecting the victims of elder abuse, the Committee sought to determine what role the Federal Government might assume in assisting the States in protecting older persons.

In its questionnaire, the Committee asked the States if they would favor federal legislation to establish model mandatory reporting requirements for elder abuse to be adopted by the States. As Table XII indicates, the overwhelming majority of the States, fully 84 percent, reported that they would favor such legislation. Only seven States, Alaska, Connecticut, New York, Oklahoma, South Dakota, Utah and Washington reported that they would not be in favor of such legislation. The States which said no, raised questions about who should be required to report incidents of elder abuse. They suggested that some categories could be easily agreed upon such as physicians, social workers and law enforcement officials but others such as private citizens unrelated to the abused, town officials, outreach workers, local welfare workers, the clergy, etc., could find themselves facing criminal sanctions. Other States, such as South Carolina, cast these concerns aside by spelling out that similar fears had been raised but that their laws are seemingly working well. For example, the State of South Carolina's statute provides for legal immunity as well as anonymity for the reporter if that party so desires. Thus, a person with information merely needs to make an anonymous call or send an unsigned letter to the Protective Service Agency in order to trigger a full investigation. Several States commented that this kind of a mandatory reporting law is crucial to alleviating the problem of elder abuse which involves family members who quite often keep a case from coming to the attention of the authorities.

The Committee found that many of the advocates of Federal involvement in the area of adult protective services suggest that one way to encourage States to make necessary statutory and administrative changes would be to make Federal funding for elder abuse-related programs contingent on certain State level requirements. The Child Abuse Prevention and Treatment Act uses this approach in distributing funds to the States for child abuse-related programs, and almost every State has come into compliance with the requirements. North Dakota indicated that Federal assistance would be necessary to encourage the States to implement elder abuse statutes: "To implement the legislation (our State) would need an allocation of approximately $300,000 per year and I can't imagine an appropriation that size passing Congress."

Legislation was introduced during the 96th Congress which uses this "child protective services method" to encourage States to modify their elderly abuse-related law and procedures. This legislation was reintroduced in the 97th Congress as H.R. 769 (H.R. 7551 during the 96th Congress), the Prevention, Identification and Treatment of Adult Abuse Act of 1981. This bill, if passed, would establish a National Center on Elder Abuse in the Department of Health and Human Services, to develop and disseminate information and materials, conduct research, and provide technical assistance for the prevention and treatment of elder abuse. The bill would also authorize (1) direct grants to public agencies and private nonprofit organizations, and (2) State grants to qualifying States, for projects related to preventing, identifying and treating elder abuse. The bill further provides that, in order for States to qualify for Federal funds, they must fulfill certain requirements, including provisions for mandatory reporting of elder abuse, prompt investigation of such reports, and immunity from prosecution for those who report suspected abuse; assurances of cooperation between State agencies, law enforcement officials, and the courts with respect to abuse cases; and assurances that the abused elder will participate in decisions regarding his or her welfare.

The Committee asked the States if they could support H.R. 769. Fully 74 percent of the responding States answered in the affirmative with 26 percent undecided. Interestingly, no State indicated they would be opposed to the measure. See Table XIII.

The New Jersey Department of Human Services commented that they supported the intent of H.R. 7551, and additional Federal funds for adult protective services program development. However "we are concerned about one of the prerequisites for Federal funding, a mandatory reporting system. If creation of a reporting system precedes program development, crises and abuses will be reported without the concrete support services to remedy them, thus misleading the public and frustrating agencies."

It is apparent that the States are anxious to begin working with the Federal government to develop programs geared toward protecting abused elderly. The majority of State statutes are ineffective in this regard. Asked to what extent the needs of the abused elderly are met through existing State laws or regulations, 35 percent of the States selected the word "occasionally." Nineteen percent more said they were simply unsure how often the needs were being met. No State said the needs of the elderly were always being met. A few States did not respond and the remainder chose the word "frequently" to describe their experience.

As is the case with most family problems, there is continuing controversy over whether the Federal government should get involved in trying to solve the elder abuse problem. Some feel that family matters should be under State and local jurisdiction, or that families should be encouraged to solve their own problems without any government intervention or expenditures. Others maintain that strong, healthy families are an important national resource and that the government should provide assistance and support when necessary, to enable the family to function optimally.[2]

Family violence of any kind—parent-to-child, spouse-to-spouse, or child-to-parent—is particularly abhorrent to many, and it is likely that public pressure for a Federal solution to these problems will continue.[3]

---

[2] Fowler, Jan, *Domestic Violence: Elder Abuse*, Education and Public Welfare Division, Library of Congress, Congressional Research Service, February 6, 1981, pages 6–7.
[3] *Ibid.*, page 7.

TABLE XI

State	Adult protective service law?	Year passed	Mandatory reporting provisions	Legislation pending
Alabama	Yes	1977	Yes	No.
Alaska	No		No	No.
Arizona	Yes	1980	No	No.
Arkansas	Yes	1977	Yes	No.
California	No		No	Yes.
Colorado	No		No	Yes.
Connecticut	Yes	1978	Yes	No.
Delaware	No		No	Yes.
Florida	Yes	1977	Yes	No.
Georgia	No		No	Yes.
Hawaii	No		No	No.
Idaho	No		No	No.
Illinois	No		No	No.
Indiana	No		No	No.
Iowa	No		No	No.
Kansas	Yes	1980	No	No.
Kentucky	Yes	1976	Yes	No.
Louisiana	No		No	No.
Maine	Yes	1964	No	Yes.
Maryland	Yes	1977	No	No.
Massachusetts	Yes	1980	No	Yes.
Michigan	Yes	1976	No	Yes.
Minnesota	Yes	1980	Yes	Yes.
Mississippi	No		No	Yes.
Missouri	Yes	1980	Yes	Yes.
Montana	Yes	1975	No	No.
Nebraska	Yes	1978	Yes	No.
Nevada	No		No	No.
New Hampshire	Yes	1977	Yes	No.
New Jersey	No		No	Yes.
New Mexico	No		No	Yes.
New York	Yes	1979	No	Yes.
North Carolina	Yes	1973	Yes	No.
North Dakota	No		No	Yes.
Ohio	No		No	Yes.
Oklahoma	Yes	1977	Yes	No.
Oregon	No		No	Yes.
Pennsylvania	No		No	Yes.
Rhode Island	Yes	1980	No	No.
South Carolina	Yes	1974	Yes	No.
South Dakota	No		No	No.
Tennessee	Yes	1978	Yes	No.
Texas	No		No	No.
Utah	Yes	1977	Yes	No.
Vermont	Yes	1980	Yes	No.
Virginia	Yes	1977	Yes	Yes.
Washington	No		No	Yes.
West Virginia	No		No	Yes.
Wisconsin	Yes	1973	No	No.
Wyoming	No		No	Yes.
District of Columbia	No		No	Yes.
Puerto Rico	No		No	Yes.

TABLE XII

V. 3. Would you favor *Federal* legislation to establish model mandatory reporting requirements for elder abuse to be adopted by the States? If yes, who should be required to report?

State	Yes	No	If yes, who would be required to report?
Alabama	X		Social workers, law enforcement, and health personnel.
Alaska		X	
Arizona	X		Physicians, social workers, others working with elderly.
Arkansas	X		
California	X		County welfare/social service department, law enforcement, hospitals, physicians.
Colorado	X		Health personnel, social workers, law enforcement.
Connecticut		X	
Delaware			
Florida	X		Any person suspecting/having knowledge of abuse.
Georgia	X		
Hawaii	X		Health personnel, social workers, law enforcement.
Idaho	X		Any person suspecting/having knowledge of abuse.
Illinois	X		Do.
Indiana	X		Do.
Iowa	X		Those required to report child abuse.
Kansas			
Kentucky	X		
Louisiana	X		Health personnel, social workers, law enforcement officers.
Maine	X		Health and legal professionals, State and local officials.
Maryland			
Massachusetts	X		Health personnel, social workers, law enforcement officers.
Michigan	X		Do.
Minnesota	X		
Mississippi	X		Do.
Missouri	X		Doctors, accountants, nurses.
Montana	X		Police, investigators, doctors.
Nebraska	X		Any person suspecting/having knowledge of abuse.
Nevada	X		Do.
New Hampshire	X		Doctors, public in general.
New Jersey	X		Any person suspecting/having knowledge of abuse.
New Mexico	X		Staff of Human Service Department.
New York		X	
North Carolina	X		Any person suspecting/having knowledge of abuse.
North Dakota			
Ohio	X		Do.
Oklahoma		X	
Oregon	X		Area agencies on aging staff.
Pennsylvania	X		Should be decided by States.
Rhode Island			
South Carolina	X		Any person suspecting/having knowledge of abuse.
South Dakota		X	
Tennessee	X		Do.
Texas	X		
Utah		X	
Vermont			
Virginia	X		
Washington		X	
West Virginia	X		All social service agencies.
Wisconsin	X		All health, social service, and Outreach workers.
Wyoming	X		All social service agencies.
District of Columbia	X		Health personnel, social workers, law enforcement officers.
Puerto Rico			
Total	38	7	

TABLE XIII

V. 4. Would you support the passage of H.R. 7551, the "Prevention, Identification and Treatment of Adult Abuse Act of 1980?"

State	Yes	No	Undecided
Alabama			X
Alaska			X
Arizona	X		
Arkansas	X		
California	X		
Colorado	X		
Connecticut	X		
Delaware			
Florida	X		
Georgia			X
Hawaii	X		
Idaho	X		
Illinois	X		
Indiana	X		
Iowa			X
Kansas			
Kentucky	X		
Louisiana	X		
Maine	X		
Maryland	X		
Massachusetts	X		
Michigan	X		
Minnesota	X		
Mississippi			
Missouri			X
Montana	X		
Nebraska	X		
Nevada			X
New Hampshire	X		
New Jersey	X		
New Mexico	X		
New York			X
North Carolina	X		
North Dakota			X
Ohio	X		
Oklahoma			X
Oregon			X
Pennsylvania			X
Rhode Island			
South Carolina	X		
South Dakota	X		
Tennessee	X		
Texas	X		
Utah	X		
Vermont			X
Virginia	X		
Washington	X		
West Virginia	X		
Wisconsin	X		
Wyoming	X		
District of Columbia	X		
Puerto Rico			
Total	35	0	12

In summary, it is clear that elder abuse is a significant problem of growing importance to the State Human Service Departments. It seems just as clear that State statutes are with singular exceptions, inadequate to fully meet the needs of the elderly. It is also apparent that States are concentrating most of their funds and resources in providing protective services to children, as 46 States require the mandatory reporting of child abuse. What appears just as obvious is that the States and the Federal government must work together to improve the protections available to the aged and prevent them from being abused financially, physically or psychologically. The States which have successful programs are lasting reminders that such abuse is not an inevitable consequence of events woven into the American fabric of life late in the 20th century. Elder abuse can be prevented and citizens can be protected from abuse if there is but the will to do so in the form of forthright legislation effectively enforced.

The following section of this report will provide an overview of Congressional interest in family violence over the years.

VI. FEDERAL INTEREST IN FAMILY VIOLENCE[1]

A. CHILD ABUSE

The first aspect of family violence to come to the attention of the American public was child abuse. In 1874, child abuse surfaced as a problem when a concerned neighbor of an abused 8-year-old child named Mary Ellen Wilson pleaded with Mr. Henry Bergh, the founder and president of the American Society for the Prevention of Cruelty to Animals (ASPCA), to come to the child's aid. This concerned neighbor sought the help of the ASPCA because there were laws to protect animals from mistreatment but there were no laws to protect children from abuse.

Mary Ellen Wilson had been cruelly beaten and rigidly confined for the six years she lived with her adoptive parents, the Connollys. Her report of the abusive treatment she sustained as it appeared in the *New York Times*, April 10, 1874, follows:

> . . . My father and mother are both dead. I don't know how old I am. I have no recollection of a time when I did not live with the Connollys. I call Mrs. Connolly mamma. I have never had but one pair of shoes, but I cannot recollect when that was. I have had no shoes or stockings on this winter. I have never been allowed to go out of the room where the Connollys were, except in the night time, and then only in the yard. I have never had on a particle of flannel. My bed at night has been only a piece of carpet stretched on the floor underneath a window, and I sleep in my little under-garments, with a quilt over me. I am never allowed to play with any children, or to have any company whatever. Mamma (Mrs. Connolly) has been in the habit of whipping and beating me almost every day. She used to whip me with a twisted whip—a raw hide. The whip always left a black and blue mark on my body. I have now the black and blue marks on my head which were made by mamma, and also a cut on the left side of my forehead which was made by a pair of scissors (Scissors produced in court). She struck me with the scissors and cut me: I have no recollection of ever having been kissed by anyone—have never been kissed by mamma. I have never been taken on my mamma's lap and caressed or petted. I never dared to speak to anybody, because if I did I would get whipped. I have never had, to my recollection, any more clothing than I have at present—a calico dress and skirt. I have seen stockings and other clothes in our room, but was not allowed to put them on. Whenever mamma went out I was locked up in the bedroom. I do not know for what I was whipped—mamma never said anything to me when she whipped me. I do not want to go back to live with mamma, because she beats me so. I have no recollection of ever being on the street in my life.

Mr. Eldridge T. Gerry, the lawyer who represented the ASPCA on behalf of the child, took the case to the Supreme Court and argued that a child was a member of the animal kingdom and therefore entitled to the same protections afforded to animals under the law. Mr. Bergh and Mr. Gerry were successful in winning the case of Mary Ellen Wilson, and the child's legal custodian was found guilty of assault and battery and sentenced to one year's imprisonment at hard labor. It was the case of little Mary Ellen which led Mr. Eldridge Gerry to form the Society for the Prevention of Cruelty to Children.

As a result of the publicity generated by the Wilson case, (see *New York Times*, April 10, 11, 14, and 22, 1874 and December 27, 1875 in Appendix II of this report) the State of New York enacted this country's first child abuse law. The law authorized "cruelty societies" to file complaints for the violation of any laws related to children and required law enforcement and court officials to aid the societies. Other cities followed the lead of New York, and by 1922, there were 56 Societies for the Prevention of Cruelty to Children. Because of the gradually increasing involvement of government into child welfare, the number of these private organizations has now declined.

---

[1] For the purposes of this report, "family violence" would include child abuse, spouse abuse, and any cases of non-institutional violence against members of a household, regardless of age; "child abuse" would be limited to persons up to 18 years of age; "adult abuse" would include all those not presently covered by "child abuse," i.e., all cases including people over 18 years old; "domestic violence" as used in the legislation of 1980 is limited to married persons, or persons living in the same residence and is generally thought of as spouse-abuse, especially wife-beating.

Not only publicity but advances in medical technology contributed to the recognition of child abuse as a widespread and increasing problem. Prior to the 1900's, one of the main factors which prevented the prosecution of suspected child abusers was the lack of scientific evidence to determine whether physical injuries were in fact deliberately caused or accidental. However, in the early 20th century, the development of more sophisticated techniques in pediatric radiology allowed the detection of abnormal fractures and other injuries which are caused by deliberate assault. As a result of the heightened awareness of incidences of child abuse, public reaction gradually increased and led to the enactment of State laws to protect children from deliberate assult.

In December, 1963, child abuse was first brought to the attention of national legislators by an important broadcasting company in Washington, D.C. A public affairs documentary and editorial by WMAL radio and television stations emphasized the "dire need to protect children against willful physical abuse." Further, the editorial encouraged the introduction of legislation which would mandate reporting of suspected cases of child abuse and grant immunity for doctors who reported cases in the city of Washington, D.C. On January 16, 1964, Representative Multer (N.Y.), a member of the U.S. House District Committee, responded to this public plea by introducing a bill (H.R. 9652) "to provide for the mandatory reporting by physicians and institutions in the District of Columbia of certain physical abuses of children."

The Washington television and radio station (WMAL) continued their editorial support of this legislation and in May, 1964 demanded that "Congress should promptly hold hearings and expedite passage of corrective legislation."

Although this bill was not passed during the 88th session of Congress, it was reintroduced in both the House (Multer, H.R. 3394) and Senate (S. 1318) in 1965. On September 30, 1965, a bill similar to the original Multer bill was finally approved by both Houses and signed into law.

Between 1963 and 1969, all 50 States passed some form of child abuse statute, and all but 4 included mandatory reporting requirements. Although laws existed in all the States to prevent or treat those children in need of protective services, few services were available to do so. As incidences of child abuse became more widely recognized as a serious and widespread national problem, the need for Federal legislation and funding became more apparent.

Recognizing the need for Federal financial support of programs to provide protection and rehabilitation services for abused children and their parents, Congressman Mario Biaggi (N.Y.) introduced the first National Child Abuse Act (H.R. 11584) in 1969. This bill provided for the protection of children under 16 years of age who were physically injured or threatened with physical injury by those responsible for their care. Additionally, the bill: (1) required mandatory reporting by doctors, teachers, social workers, and welfare workers; (2) made failure to report a misdemeanor; (3) granted immunity to any person filing a report in good faith; and, (4) provided for a child identification system through the issuance of a Social Security number to infants at birth.

The media continued to be influential in focusing attention on the problems of child abuse and the need for additional services and legislation to deal with this serious national problem. (See series of articles from *Detroit News, Congressional Record*, May 22, 1969, in Appendix III of this report). A May 1969 *New York Times* article reported a 30 percent increase in the number of cases of child abuse reported to the New York State Department of Social Welfare. (See Appendix IV of this report). In November 1969, syndicated columnist Jack Anderson wrote an article describing child abuse as a "national scandal that has been kept in the shadows." He cited statistics of the American Humane Society estimating that "10,000 children are beaten, burned, boiled, and deliberately starved in the United States each year by parents, relatives and guardians."

Despite the continued public attention to the problem of child abuse, no floor action was taken on the National Child Abuse Act, which was reintroduced in each session of the Congress. On March 16, 1972, Congressman Biaggi and 26 cosponsors again reintroduced the bill and stated:

> . . . the insidious crime of child abuse and neglect by persons responsible for a child's care is the number one cause of death among children under the age of 5. . . . In New York City alone . . . the incidence of child abuse rose 549 percent from 1969 to 1970. This is only a fraction of the total, however, since the majority of these cases go unreported.

In March and April, 1973, Senate hearings were held before the Subcommittee on Children and Youth of the Committee on Labor and Public Welfare. These hearings emphasized the need for Federal funds for comprehensive programs to provide protective services for thousands of abused and neglected children. Several Members of Congress and expert witnesses at the hearings testified that the legislation was too narrow. One Member of Congress pointed out that "there are lots of horrible crimes committed against persons above the age of 18. There are lots of old folks being abused"[2]

On January 31, 1974, the Child Abuse Prevention and Treatment Act (P.L. 93-247) was enacted to provide Federal financial assistance for the identification, prevention, and treatment of child abuse and neglect. The Act was amended by P.L. 95-266 on April 24, 1978, and reauthorization was extended until 1982. The original Act provided for the establishment of a National Center on Child Abuse and Neglect to collect and disseminate information on the subject as well as the incidence of child abuse and neglect. Additionally, it mandated the creation of an advisory Board on Child Abuse and Neglect to assist the Secretary in coordinating Federal programs relating to child abuse and neglect and in developing Federal standards for child abuse programs.

In the 1977 Congressional hearings on the "Extension of the Child Abuse Prevention Act," the question of the narrow scope of the legislation was again raised. Testimony from expert witnesses recommended that the program consider the entire scope of violence in the family.

B. SPOUSE ABUSE

As American society began to recognize and deal with the problem of child abuse, it became increasingly more evident that abuse of children was not the only aspect of family violence. Research and attention to the problem of family violence uncovered statistics such as the following:

> Over one million children are abused each year, physically, sexually, or through neglect. About 240,000 children are victims of physical abuse and at least 2,000 of them die of their injuries.[3]
>
> In any one year, approximately 1.8 million wives are beaten by their husbands. Over 25 percent of all American couples engage in at least one violent episode during their relationship.[4]
>
> In 1977, nearly 20 percent of all murder victims in the United States were related to the assailants. About half of these intra-family murders were husband-wife killings.[5]

In addition to recent research on family violence, issues related to child abuse and wife beating were brought to the public's attention by the media. This growing awareness of the prevalence of family violence prompted Federal action.

In 1977, during the 95th Congress, bills were introduced in both the House and the Senate to establish a Federal office on "domestic violence" and to make grants for shelters and other projects to assist "domestic violence" victims. (As noted earlier, "domestic violence" as used in this legislation is limited to married persons, or persons living in the same residence; "domestic violence" is generally thought of as spouse-abuse, especially wife-beating.) The Senate passed their version of the bill but the House failed to act during the session, and the measure died.

In the 96th Congress, bills were again introduced in both the House and the Senate to provide Federal funds for programs to prevent domestic violence, assist victims of domestic violence, and to provide for the coordination of Federal programs pertaining to domestic violence. Domestic violence bills were passed in both the House and the Senate in December 1979 and September 1980 respectively. However, the final conference report was never acted on by the Senate and the measure again died at the end of the 96th Congress.

---

[2] Representative Treen, *Congressional Record*, December 3, 1973, H-39231.

[3] "New Light on an Old Problem," U.S. Department of Health, Education, and Welfare, 1978, p. 1.

[4] Straus, Murray A., "Wife Beating: How Common and Why?" in "Victimology: An International Journal," November 1977, p. 445

[5] "FBI Uniform Crime Reports: Crime in the United States, 1977," U.S. Department of Justice, October 18, 1978, p. 9.

At the beginning of the 97th Congress, in January 1981, Congressman Mario Biaggi introduced the "Domestic Violence Prevention and Services Act," H.R. 1007, which essentially contained the provisions of the final conference report from the bills acted on in the 96th Congress. The purpose of this Act is to: (1) increase participation by States, local public agencies, local communities, nonprofit private organizations, and individual citizens in efforts to prevent domestic violence and to provide immediate shelter and other assistance for victims and dependents of victims of domestic violence; (2) to provide technical assistance and training relating to domestic violence programs; (3) to establish a Federal inter-agency council to coordinate Federal programs and activities relating to domestic violence; and (4) to provide for information gathering and reporting programs relating to domestic violence. Additionally, this bill would mandate that the Secretary of Health and Human Services conduct a study of the nature and incidence of abuse of elderly individuals. Sixty-five million dollars would be authorized over a three-year period to carry out the purposes of this bill.

C. ADULT ABUSE

Providing services for abused Americans has been approached in a fragmented way as is evidenced by the various legislative solutions which deal with selected populations of vulnerable Americans. A comprehensive legislative solution to the problems of all vulnerable Americans—whether they are women, elderly, mentally or physically handicapped, institutionalized, living alone in the community, or living with others—was proposed by Representative Mary Rose Oakar in June 1980 (H.R. 7551). The intent of "The Prevention and Treatment of Adult Abuse Bill of 1980" was to provide financial incentives for States to enact appropriate protective services legislation, since the legislation jurisdiction over family matters lies with the State government rather than with the Federal Government.

The purposes of the Adult Abuse Bill of 1980 were: to provide financial assistance for programs of prevention, identification and treatment of adult abuse, neglect, and exploitation; and to establish a National Center for Adult Abuse. This bill would provide Federal funds to States which had mandatory reporting laws and provided for immunity from prosecution for persons reporting incidences of abuse, neglect and exploitation. Additionally, States must have trained personnel and services available to abused, neglected and exploited adults.

After H.R. 7551 was introduced on June 11, 1980 at a Joint Hearing of the Senate and House Committees on Aging, the bill was referred to the Committees on Interstate and Foreign Commerce, and Education and Labor. No Committee action was taken during the 96th Congress, although 39 Members of Congress had cosponsored the bill.

When the States were asked, in a questionnaire (See Appendix I) if they could support this legislation, the overwhelming majority indicated they could. A number of States were undecided. No State indicated their disapproval of this legislation.

D. ELDER ABUSE

As noted earlier in this report, the increasing amount of mail received from senior citizens, aging organizations, and others led the House Select Committee on Aging to hold four hearings on the subject of elder abuse. The first was in Boston, Massachusetts, on June 23, 1979 with Congressman Robert F. Drinan presiding. The second was held in New York City on April 21, 1980 with Congressman Mario Biaggi, Chairman of the Subcommittee on Human Services presiding. On April 28, 1980, a third hearing was held in Union City, New Jersey, chaired by Congressman Matthew Rinaldo, now ranking minority of the Committee. A fourth hearing was held in Washington, D.C. sponsored jointly by the House Select and the Senate Special Committee on Aging. Congressman Claude Pepper, Chairman of the House Committee and Senator David Pryor cochaired the hearing. Following are highlights from each of these hearings.

BOSTON

Congressman Robert Drinan opened the hearing saying the notion of physical abuse of the elderly by their loved ones shocks us all but recent studies indicate the problem may occur with alarming frequency. He pointed out that there had been little hard data on the topic to date and expressed the hope that this first ever Congressional hearing on the subject would serve to sensitize the public and lead to Congressional reform.

Dr. Thomas H. D. Mahoney, Secretary of the Department of Elder Affairs in the Commonwealth of Massachusetts, concurred that "abuse and neglect of elders is a very serious problem . . . for the abused elders, their families, and for their friends. It is also a matter of great concern to the providers of medical and legal and social services . . . we are in our infancy in our recognition of this problem."

James A. Bergman, regional director of the Legal Research and Services for the Elderly (LRSE) in Boston made the point that until society recognizes elder abuse as a serious problem, no serious reforms will be instituted. He analogized the problem to child abuse and spouse abuse, both of which he said were not generally condoned but they were not widely condemned either until interest groups began to make the issues matters of national importance. He pointed out the difficulty in getting information about the abused elderly since many of them are ashamed or unwilling to admit they have been abused. He underlined the importance of this, the first Congressional hearing on elder abuse, saying, "If the war against elder abuse is to start, let it start here."

Mr. Bergman reported on the results of his survey which was sent to about 1,000 professionals in Massachusetts. Some 34 percent replied to the survey and of this number 183, or 55 percent, reported coming in contact with an elder abuse case or cases within the past 18 months. Significant findings of the survey include:

1. Almost all professions surveyed indicated that they knew of cases of elder abuse, with visiting nurses, hospital social services directors, private social service agencies and home care corporations accounting for the majority of abuse citings.
2. Incidents of abuses tended to be recurring events and not single occurrences: 78 percent of the respondents indicated the abuse had occurred twice or more.
3. Outside (third-party) observation tended to be the primary means of identifying abuse cases: in at least 70 percent of the abuse citings, someone other than the victim or his/her family brought the case to the attention of concerned professionals or paraprofessionals.
4. Physical trauma constituted over 41 percent of the reported injuries and included bruises, welts, cuts, punctures, bone fractures, dislocations, and burning. Other types of abuse included verbal harassment, malnutrition, financial mismanagement, unreasonable confinement, over sedation and sexual abuse.
5. Victims of abuse were likely to be very old (75 and over) rather than younger (60–75).
6. Women were more likely to be abused than men, regardless of age.
7. In 75 percent of the abuse citings, the victim had a mental or physical disability which prevented him or her from meeting daily needs.
8. In 75 percent of the abuse citings, the victim lived with the abuser and in 84 percent of the citings, the abusing person was a relative of victim.
9. Almost three-quarters of the surveys stated that the abuser was experiencing some form of stress such as alcoholism or drug addiction, a long term medical complaint or long term financial difficulties.
10. Often (in 63 percent of the surveys), the elder victim was a source of stress to the abuser, primarily because the elder required a high level of physical or emotional care for the abuser (such as personal care, preparing meals and administering medication) or was financially dependent on the abuser.
11. A wide variety of intervention strategies were described by respondents, including referral to social services agencies, counseling, arrangements of in-home services and removal of the victim. Temporary or permanent removal of the victim from the abusive situation was frequently cited.
12. 70 percent of all surveys indicated that some barrier to service provision was experienced by workers. A particular problem was the refusal of the victim to acknowledge the problem or allow corrective action to be taken. Reasons given for this inaction were fear of retaliation or shame. Respondents cited the lack of legal protection for workers who wish to intervene in the abuse situation. Lack of respite care facilities, temporary shelters and protective services for elders were also cited as barriers in dealing with abuse cases.

Mr. Bergman described a dramatic case of a husband and wife who separated and yet the wife continued to live with her mother-in-law. Over time, resentment turned to neglect and finally to violence. The older woman became a virtual prisoner in her home. Only when faced with eviction because conditions in the house had so poorly deteriorated as to be a health hazard did the victim cooperate with protective service workers. Mr. Bergman said the case typified many of the instances which his agency was dealing with:

> In this case, as in many others, the older person was not very mobile; she was somewhat dependent upon the person who was abusing her; she was being financially exploited: she was being beaten as well as mentally abused and the abuser herself also had a very serious problem—alcoholism. The abuse continued for a very long period of time. We also see that the victim was not the person who reported the abuse case. It was a third party, a neighbor. The victim did not want to do anything about that abuse situation initially. It took extended time and contacts with workers before the elder agreed to protect herself. Had the workers not been keeping that regular contact, the eviction probably would have occurred and the situation would undoubtedly not have improved at all.

Mr. Bergman said there was room for action at the Federal level. First, he called for more hearings by the Committee and second, for the funding of some research in the area by the Administration on Aging. Third, he suggested that Title XX of the Social Security Act be amended. This program provides 75 percent Federal matching funds to the States for social services provided to low income individuals through State and local agencies under contract. He asked that the law be amended to allow the States to use Title XX funds for adult protective services and suggested that the Federal matching for this one purpose be increased to 90 percent as an inducement to the States.

Helen O'Malley, also with LRSE, said in part, "Our findings about the recurrent nature of abuse make it likely that we will be seeing more rather than less of this problem in coming years." She painted the picture of the abused elder as someone quite old (age 75–80) and likely to be a woman. She said that three out of four cases involved people with disabilities who were dependent and could not care for their own needs and that 75 percent of the abused lived with their abuser. She added that in over 80 percent of the cases found, the abuser was a relative. "It looks like abuse, like charity, begins at home," she said. She stressed the importance of the statistic that three-fourths of the abusers were suffering from severe stress brought on by alcoholism, addiction, medical or long term financial problems. She added that victims seldom report cases—70 percent were reported by third parties. Also, she said it seems that violence can be passed from one generation to another. "If you are an adult and as a child you were battered, you are likely to batter an adult. In families where child abuse is going on, the child is more likely to abuse the parent (when grown)." She closed by pointing out that caseworkers had great difficulty getting access to victims and more difficulty bringing about a successful resolution to the problem if the victim will not register a complaint.

Brian Langdon, Director of Family Services Association of Greater Lawrence, Massachusetts, also began on this same note: how difficult it was to document emotional and physical abuse of the elderly. He shared with the Committee a number of case histories including a case of a woman who had four sons, none of whom would accept responsibility for her care. The sons accused each other of attempting to pilfer their mother's estate. Social workers were unable to get the brothers to agree even on a plan which would have provided a few hours of home health services each week. The woman died for the lack of care and services. In another case, a 68-year-old mother could not bring herself to bring charges against an abusive son who stole her property and ran up huge charges on her credit cards. The son was a heroin addict who had been in prison but embarrassment, shame, and love prevented the woman from pressing charges. He added the case of an 86-year-old woman who was neglected. It was reported the woman became confused and was seen walking around the neighborhood dressed in nightclothes and slippers in the middle of the winter. Asked to differentiate between neglect and abuse, he said: "I think as with children, neglect becomes abuse. Neglect is the first step toward more serious physical abuse."

Meredith Savage, regional ombudsman, Department of Aging, State of Connecticut, provided additional case histories including a story of an 86-year-old woman who was found suffering from multiple bruises, chained to a metal chair. The son-in-law, with whom she lived, was known to be violent and armed most of the time. He had served time in prison for attempted murder. The man threatened police and caseworkers who sought to come to the woman's rescue. Additional cases were provided by Meg Harari, a caseworker with the Family Service Association of greater Boston and by Howard Segars, a psychologist with LRSE, as well as Russs Moran, Director of Elder Services of Merrimack Valley, Inc., Massachusetts. Segars commented:

> I have repeatedly seen middle aged children threatening their parents with nursing home placement for whatever the reason, whether it is to gain control of resources or simply to relieve themselves of the tedious task of care. I have seen people overmedicated because physicians have said "when your mother starts to act up, give her two of these." If two are good, four are better, and six more is best.

Moran commented that there was a paradox in that families that try to take care of their relatives are penalized because of lack of supportive services or tax incentives whereas those families that abandon their loved ones are rewarded by having Medicaid take care of them.

Karen Myers, an attorney with LRSE, suggested that the Federal government could play an important role in developing a model adult protective service law which could be enacted by the States. Jacqueline Walker, State Nursing Home Ombudsman from Connecticut, provided details of the Connecticut law which is generally regarded as the best and most progressive in the Nation. She credited Congressman William Ratchford, a Member of the House Select Committee on Aging, and former Commissioner on Aging in Connecticut, for the enactment of this reform measure. She said:

> Since the program has been in effect, there has been an overload of (elder abuse) cases reported to our office. More cases than we ever anticipated. The ombudsmen were astounded, sickened and shocked to see the severity of problems which abound in the community. Problems, which until this time, have been unnoticed by agencies and community officials.

Ms. Walker presented numerous examples of elder abuse which she said were typical. She noted that almost 1,000 cases were reported during the first year the statute was in effect.

Ms. Walker highlighted the importance of the State's mandatory reporting law but noted, "we fully realize that there are endless numbers of cases which are still hidden away waiting to be uncovered."

NEW YORK CITY

In his opening statement, Congressman Mario Biaggi, Chairman of the Subcommittee on Human Services, described the problem of domestic violence and the elderly as "a burgeoning national scandal." He said that up to now, "abuse in nursing homes has received the lion's share of publicity. As a result of public awareness, the problem has diminished in scope. Similarly, if prevention of further cases of elder abuse is to take prominence, then it is imperative that sufficient attention be focused on the problem." He cited a national study by Richard Gelles of the University of Rhode Island who estimated that each year at least 500,000 persons age 65 and over who live with younger members of their families are physically abused by them.

Chairman Biaggi then called upon Congresswoman Geraldine Ferraro to be the first witness at the hearing. Prior to her election to Congress, Ms. Ferraro had served as an assistant district attorney in Queens. She founded and was chief of a special victims bureau which handled crimes involving senior citizens and intrafamilial violence. Ms. Ferraro underscored the point of how difficult it is to get victims to step forward and press charges:

> Parents never cease being parents. They continue to protect their children and shield them from the outside world. That outside world is a particularly threatening one when it is the criminal justice system. Among the victims I interviewed in the district attorney's office was an elderly couple whose daughter and her boyfriend had physically abused them. The abuse included beating them and robbing them at knife point yet they wanted the charges against their daughter dropped. Evidently their fear of repeated abuse was not as great as the embarrassment caused by admitting that their own daughter was abusing them and by actively encouraging the criminal prosecution. Moreover, this couple may have felt that were they to cut off ties with their daughter, they would leave themselves without alternatives for living arrangements as they grew older.

Ms. Ferraro added, "Unfortunately, the issue of intrafamilial violence against the elderly has been largely forgotten . . . in the formulation of national policy." She suggested amendments to Medicare and Medicaid to allow payment to senior citizen day care centers. She urged that the British idea of respite care be adopted in America. Under that plan, families may place their loved ones in community facilities paid for by the State for a few days each year to allow the caretakers to take a vacation or simply a break from "the stressful situation brought on by intergenerational living arrangements."

Congressman Thomas A. Luken participated in the hearing and began by commending the Chairman for calling the meeting. He said the very fact that the hearing was taking place would have a salutary effect. He said the hearing would help give the problem some recognition. "Now that we recognize that (elder abuse) is a phenomenon, one which is occurring . . . widely in this country," said Mr. Luken, "it is for us a matter of national policy to determine what the causes are." He suggested reforms: "I think we should consider a legislative response such as mandatory reporting."

Ralph Brewster, Director of the Brooklyn Senior Citizens Crime Victims Assistance and Prevention Program, appeared before the Committee with several case histories. One example involved a woman who lived quietly in the house she and her husband had occupied prior to his death. The woman's mother became ill so she permitted her to move into the small house with her. Thereafter, a sister and her son moved in, uninvited, and carried out a reign of terror which ended in the victim being forced out of her own home into the street. The woman had to sneak back into the home in the dead of night. The nephew assaulted the woman frequently and allegedly stole her possessions. The woman hired an attorney who threatened legal action against the interlopers who finally left.

Sergeant Joseph Fornabaio of the North Manhattan Police Precinct Senior Citizen Robbery Unit told of a 78-year-old woman who was repeatedly assaulted by her 36-year-old grandson which resulted in her hospitalization on seven occasions. Despite the fact that he had even assaulted her sexually on several occasions, the woman would not press charges. On one occasion, the grandson struck her with a cane and on another occasion, he struck her with a metal leg from her wheelchair. Neighbors agreed to press charges and the grandson was charged with six counts of assault and robbery. While the case was pending, he got out of jail on bail, went immediately to the victim's house, forced his way in and beat her up again. He was ultimately convicted and was sentenced to a term of 3 to 7 years in jail.

Lou Glasse, Director, New York State Office for the Aging, testified that elder abuse is an increasingly important problem. She lamented that:

> . . . only recently have we begun to learn about incidents of physical abuse and violence against the elderly by members of their own families. It would seem that the same savagery shown the elderly in the streets by criminals has permeated the home. The home, conceived as a place of refuge, turns out to be a very dangerous place for some older persons. Researchers estimate that 10–20 percent of families in the United States suffer from some incident of family violence and the elderly, once respected and venerated, do not escape victimization.

Mrs. Glasse said she was shocked that 87 percent of New York's protective service funds were being spent on children. She noted that only half of the remaining 13 percent is being spent on the elderly. This disparity was highlighted by figures she quoted earlier, saying: "While elder abuse appears less frequent than spouse abuse according to Block and Sinnott, it seems at least as high as child abuse." Mrs. Glasse said she was "compelled to support and advocate" mandatory reporting laws.

Congressman Matthew Rinaldo, who participated in the hearing, commented: "I think you build a case for at least an initiation into mandatory reporting so that we do have a valid body of data upon which to project future needs and services."

Barbara Blum, Commissioner of the New York State Department of Social Services, also supported the mandatory reporting idea in her statement to the Committee. She also recommended funding adult day care programs, tax and financial incentives for families who care for their loved ones at home, and the establishment of preventive and rehabilitative counseling programs.

NEW JERSEY

One week after the New York City hearing, Congressman Matthew Rinaldo chaired a similar inquiry in Union City, New Jersey. He said that while elder abuse is a newly discovered and growing problem, there are few hard figures on the incidence of "this most repugnant of all violence perpetrated against older Americans." He noted estimates run from 500,000 cases of elder abuse to more than 2 million a year.

Meyer Schreiber, Associate Professor of Social Work, Kean College, Union City, New Jersey, provided the Committee with some case histories and a series of recommendations. He suggested the Federal government help fashion model legislation to be enacted by the States, that home health care be expanded under Medicare and Medicaid, and that States implement mandatory reporting laws. He said the Department of Health and Human Services is "in the Neanderthal age" as far as the problem of elder abuse is concerned. He urged the Congress to prod the Department with legislation which is justified by the increasing number of cases even though there are no precise figures on the incidence of such abuse.

Bernice Manshell, Director of the New Jersey Division of Youth and Family Services, also provided the Committee with case histories and endorsed the idea of model elder abuse legislation. Dr. Jane Handler, Coordinator of Family Studies at Kean College, stressed the importance of programs such as foster grandparents which allow young people to interact with the aged. She advocated Federal subsidized day care centers for the elderly and any means to reverse and encourage the extended family concept in American life.

Robert Famighetti, Director of Gerontology at Kean College, quoted national studies as well as his personal interviews with colleagues all across New Jersey to suggest that elder abuse was an important and growing problem. He provided several examples and noted that with the cost of living rising and more and more women entering the work force, the problem of parent neglect and abuse is likely to increase.

Irene Salayi, Director, Glen Garden Center for Geriatrics in Union, New Jersey, endorsed the idea of respite care to relieve families temporarily of the burdens which they carry, often beyond the point of endurance. Chairman Rinaldo noted that he had proposed the same idea in his opening statement.

Veronica Kane of the New Jersey Federation of Senior Citizens, who previously worked as a senior intern in the office of Chairman Rinaldo had these comments:

> We must now realize that children and battered women are not the only family members who take beatings from their loved ones. The battering of aged parents has joined the ranks for many reasons, first to control their behavior, to force their signature on wills, force them to turn over stocks and bonds or money in the bank.
>
> Improper care or lack of care, both physical and medical, like withholding food or withholding medicine, and general neglect and even isolation at times leading to physical and psychotic behavior which results from prolonged lack of sensory stimulation. Intense verbal abuse, I know one daughter that calls her mother who is bedridden every day on the phone and just annoys her by saying,—the woman, by the way, is bedridden and has had a stroke, and she keeps saying to her, "you could do something if you wanted to. You could get up out of bed. You don't need to be a burden to us," and this goes on indefinitely. "You can walk if you want to. You are just looking for help. You are killing all of us. You just don't want to do anything," and I have been in her home when this happened and I have heard it. Then there are threats of putting them in a nursing home, and even threats of turning them out of their house with nowhere to go.

Mrs. Kane said that money had been set aside for protective services for abused children and spouses and now some funds must be made available to aid the elderly. In addition, she talked about the need to fill the gaps in Medicare since increasing health care costs can bankrupt the elderly and put them in a position of depending on loved ones. She said in part:

> We must also look to take care of items that are uncovered by Medicare. This is a problem to the people who are taking care of them, like eyeglasses, we give them a paper to read and they can't see it. They need hearing aids. We put a television in front of them and they can't hear it, and we give them nutrition programs, but no teeth to eat the food with, and they also need prescription drugs, which we thank God we have here in New Jersey.

James Pennestri, Director of the New Jersey Division on Aging, recommended the enactment of mandatory reporting laws as well as the creation of a National Center for Elder Abuse modeled on the National Center on Child Abuse. He called for more detailed studies to provide better data on the incidence of older abuse. Edith Fleshner, Director of Bergen County's Adult Protective Services Program told the Committee that they are confident there are a great many more cases of elder abuse—particularly of financial abuse of the elderly than are reported each year. She said:

> We believe this is due to the absence of protective service legislation which would mandate the reporting of suspected abuse; designate an agency to investigate all cases in which abuse was reported; and grant immunity to both the reporters and others involved in the investigatory process. The provision of legal protection and procedures would encourage concerned persons to report suspected abuse.

WASHINGTON, D.C.

In June 1980, the House and Senate Committees on Aging held joint hearings on the topic of elder abuse. Chairman Lawton Chiles of the Senate Aging Committee, said, "I wish this was one hearing we didn't have to conduct." He said was sure the vast majority of older people are receiving the needed help from their families and friends. However, he said, "we still know that there is a problem and it seems to be a growing one." Ranking minority member Pete V. Domenici also expressed regrets in having to deal with the matter. "Unfortunately, though, the syndrome of the battered elder appears to be quite prevalent—some studies reveal that it rivals child abuse in frequency."

Senator David Pryor who co-chaired the hearing also noted that "elder abuse may occur as frequently as child abuse although he said the studies are by no means conclusive on this point." He noted that in times of high unemployment and inflation, experience with child abuse indicates the incidence of abuse increases. He said it was likely the incidence of elder abuse follows a parallel course. He noted that he recognized the problem when he was Governor of Arkansas and was instrumental in having the State enact its adult protective service law.

Chairman Claude Pepper of the House Select Committee on Aging described the results of the Committee's questionnaire to police chiefs in America's major cities. The preliminary conclusion from the study was that the problem of elder abuse was a serious problem and becoming worse all the time. He gave this example which was submitted by the Atlanta Chief of Police:

> Mrs. M is 60. Mr. B, her son, is 27. She has prosecuted him four times for simple battery of her. He does not work, she is terrified of him and does not let him know where she lives. She also is very worried and concerned that he cannot get ongoing care as an in-patient.

Senator John Heinz (now Chairman of the Senate Committee on Aging) said it was indeed shocking to learn what the Committees had uncovered:

> When a daughter-in-law locks somebody in a closet or feeds them dog food, it is a shock. When some father is threatened with poisoning by his son, it is a shock. When a caretaker blackmails an elderly person out of all their life savings, it is a terrible, terrible abuse. We don't want to know about these things because we don't want to really believe they happen. But they do, and those are the family skeltons in the closet that must see the light of the day; otherwise, we will never be able to address the problem.

Congressman John Paul Hammerschmidt said in his opening statement that the Committee should maintain a sense of perspective. He reminded the Committee that instances of elder abuse are the abberration and not the norm.

Congresswoman Mary Rose Oakar called elder abuse a "most serious national problem" noting that she had been working for more than two years to do something about it.

> It really is a national disgrace that we have a child abuse law but we do not have an adult abuse law. I am not just talking about the older Americans, I am talking about the handicapped, mentally retarded, battered women, and so forth.

She went on to describe H.R. 7551, the reform legislation which she has authored along with Chairman Pepper.

Congressman Charles E. Grassley (now in the U.S. Senate) said:

> Recent data suggests . . . that many of the dependent elderly receive anything but love and compassionate care. The extent of such callous and in-

humane treatment is not yet well documented but there are indications that it may be broader in scope than was suspected a few years ago.

Congressman Marc Marks, now ranking minority member of the Subcommittee on Health and Long-Term Care, also suggested that the problem may be far more widespread than originally realized. He suggested that there are currently strong disincentives in Medicare and Supplementary Security Income benefits to having the elderly person live with their children which he said creates tensions which make some sort of abuse more likely. He suggested that appropriate tax credits be created to encourage multigenerational families.

Congressman William Ratchford told the Committee that Connecticut's elder abuse law evolved almost by accident. He had been named chairman of a blue ribbon commission to investigate nursing home problems. Out of that commission grew a number of recommendations which were implemented in law, including a nursing home ombudsman law which mandates reporting of abuses which take place in nursing homes. The ombudsman is empowered to investigate complaints. "We then discovered that probably there was greater abuse in the community," said Congressman Ratchford. He continued:

> One particular case was responsible for the passage of Connecticut's elderly abuse statute. In Middletown, Conn., it was discovered that a grandmother living in a tobacco road situation had been chained to her bed for the better part of 2 years. That was the family's way of coping with senility. In addition to the chaining, she had been physically abused and there was evidence of bruises of long-standing on her body.
>
> As a result of that, Connecticut passed an elderly abuse statute which mandates reporting, which allows the appointment of a conservator, which we did in this particular case, and which obviously allows for prosecution where it is necessary.

The witnesses at the hearing included three victims of elder abuse as well as their counselors or caretakers and a number of experts who have conducted elder abuse studies. Testifying first was Mrs. X of Massachusetts accompanied by Merrilyn Collins, a protective service worker from Lexington, Massachusetts and James Bergman, Director, Legal Services for the Elderly, Boston, Massachusetts.

Mrs. X who is 79 years of age, described the pattern of abuse she received from her 45-year-old daughter, the latter being a bright, well educated person with a Master's Degree in social work from Harvard University:

> My husband died 10 years ago. The house where we lived became mine, exclusively, furnishings and other materials included. My younger daughter, who had two unfortunate marriages, was welcomed by us and helped in every way we could with her and her children. This began over 18 years ago. The past 3 years, things have gotten steadily worse. My daughter locked me in the garage and left me there for more than an hour. She always parked her car behind mine in the garage so I could not get my car out except by her permission. She insisted upon a weekly time schedule of when I wanted my car in or out of the garage and she would become very upset whenever I changed the schedule.
>
> One morning she told me I could not use the bathroom or the kitchen any more. I called the Mental Health Association immediately and reported this. The doctor there called my daughter, and, whatever transpired, being barred was never mentioned again.
>
> Whenever I tried to cook a meal she would appear and turn the gas off and remove the grills so the only way I could cook was to hold the pan the right distance over the flame. Also, if she found me using the electric toaster oven, my food was thrown on the floor and the toaster oven was removed and hidden for several days. She posted a time schedule on the kitchen door as to when I could use the kitchen and the time allowed me was too short to cook a meal.
>
> During the winter months, the temperature in my bedroom was between 52 and 64. I had an electric heater, but during freezing temperatures outdoors my room never seemed to get warm enough for any length of time. I had to keep my room locked at all times for fear of what she would do to the contents if she got in. Once she got in, I would find things missing. Several times she locked me out of the house. One of those times it was very cold and snowing with ice on the ground. I had to get to a pay station to call a friend to come and get me. My daughter's treatment of me kept getting worse. Always

> hurting me physically and mentally; kicking me, pushing me, grappling with me, telling me to get out, at one time throwing a drawer down the stairs at me, calling me names, telling me I belonged in a nursing home and why didn't I go to one. I was not included in family festivities for any of the holidays. She told me I was senile and paranoid and my brain was all shriveled up.

Next to testify was William Jones from Washington, D.C. He told the Committee that five years after his wife's death, he needed assistance with his financial affairs because he could no longer make out checks. He said his son interfered and entered his name on his father's checking account. The father said that thereafter he was given virtually no money to live off of:

> I had only one meal a day and I had to live off greens and turkey wings all week and the next week was chicken wings and noodles, which had maggots in them, they finally got sour. I had to fend for myself. (M)y son shoved me over a chair and told me he wasn't going to do anything for me. I told him I was human and don't be doing that to me. He said he didn't care.

Accompanying Mr. Jones was Delores Roberts, an adult protective service worker in the District of Columbia. She testified as follows:

> As Mr. Jones stated, he came to our attention through a cousin of the family who stated that he was being exploited, abused, and neglected. When I went out initially to see Mr. Jones, he was very fearful and was reluctant to let me into his home. When I did enter the home, the home was filthy; it was infested with mice and roaches.
>
> He also showed me the guns. He had seven guns in his house, where his son had threatened to use them on him if he let anyone come into the house. The mail in the house was stacked so high because the son did not allow him to open his mail. Not only that, but he did in fact push his father around.
>
> Also, he would not allow him his moneys from a passbook savings account that he had in the bank. The day I was there, he showed me $7 that he had been saving for months. He said that just in case an emergency would happen to him he would have at least the $7.
>
> Mr. Jones' retirement checks were mailed directly to his bank and placed into his account, but all the withdrawing was done by the son. What we did, I had the bank put a red tag on his passbook to close off his account until we were able to go down to the corporation counsel's office and take out a protective order on the son. After we did that, we removed Mr. Jones from his home to a relative that kept him for a short period of time, until we were able to find placement for him.
>
> Mr. Jones went to court. Of course, his son said that he was crazy, that he had hallucinated, he was old and senile, he would run around and wander in the street; but a psychiatric examination proved to the contrary.
>
> We petitioned the court for a conservator and now Mr. Jones does have a conservator. The court ordered Mr. Jones' son out of the home, ordered him to turn over his passbook. At this point, Mr. Jones' problems have been solved, but Mr. Jones is not the only one.
>
> I have worked with the Protective Service for 10 years. I have worked in a nursing home and I worked there 7 years, and I have seen so much abuse to our elderly it is just pathetic. You would not believe some of the things, some of the horror stories. . . . I had a case where a lady—a mother-in-law as a matter of fact, 80-some years old, paralyzed—who was sexually abused by her son-in-law for 6 years. It took me a year and a half to get her to admit that to me. He also hit her on the head with a hammer when she would not give him her money or would not want to have sex with him.
>
> This lady would not leave the home; she had not been outside in years, and she was fearful of leaving the home. Finally, when I just insisted—the law said you cannot force anybody to go anywhere—but this was one time that I insisted and made other arrangements, and I moved her into another lady's home, and that is where she died.
>
> Then, the other day, I went out on a case where there was an elderly man who was lying on a mattress with the springs coming through the mattress. His apartment was infested with roaches, so many roaches it looked just like a beehive with the bees on it, and they were just crawling all over him and he was laying in his own waste matter.
>
> This kind of thing, I just cannot see why the community would let human beings live this way, neglect our elderly. It just makes me sick to see things like this and I wonder how I can go on with the cases.

> Last year, when Congressman Pepper had his hearings, I did make a statement that I thought there should be a protective service law, there should be a mandatory reporting of anything that you see—without reprisals. I would like to say to you gentlemen today that the faster you can get a law to protect the elderly the better, because I have seen 18 years of abuse and it is on record in my office. Every case that comes into our office is abuse, neglect, exploitation, or all three, and it is not isolated to the poor. It is the rich, the affluent and the poor, the rich and the middle income. It is all the way across-the-board and we cannot get any help.

Also appearing was Mrs. Z, a 92-year-old woman from California, accompanied by Marcia K. Standley of San Jose, California, an adult protective service worker with Santa Clara County.

Mrs. Standley described how Mrs. Z and her elderly sister fell under the influence of a caretaker who abused them physically and financially. Mrs. Z had had a stroke and was hospitalized. After six months in a coma "she was in a nursing home and she was very fortunate to have recovered fully with all her physical and mental faculties," said Mrs. Standley. Mrs. Z also learned that she was now a pauper. Through trickery and deceipt, the caretaker had obtained the power of attorney of the two sisters, changed their wills to make herself the beneficiary, took their jewelry and possessions, and obtained title to their house. Upon investigation by protective service workers, the above facts were uncovered. Mrs. Z denied signing over her home, or signing power of attorney, or giving away her jewelry and other property. Ultimately, the matter was resolved in court with the court appointing a guardian to look after the affairs of Mrs. Z and to recover her property.

Suzanne K. Steinmetz, Ph.D., of the University of Delaware, testified, describing her on-going study. Dr. Steinmetz delivered a thoughtful presentation saving her sharpest words for those who seemed to minimize the importance of the elder abuse problem:

> It was stated earlier that the family indeed provides very good care to the elderly person, and this is true in most cases, and that those individuals who abuse are psychopathologically ill, mentally ill. May I refresh your memories that this is exactly what we said about parents who abused their children, they were pathologically ill, yet subsequent studies show that while some of them were, most of them were as normal as you and I. We then were told the same thing about the men who beat up their wives. Again, the studies show that, like with child abuse, it is a series of circumstances such as frustration, inability to cope, lack of money, and so forth, that lead to the abuse.
>
> I think it is important that we not label people who abuse other people as pathologically ill. We live in a society where the use of violence is perfectly acceptable in a large number of cases. We grow up being socialized to use violence when we are big, when we are right, when we are older, and when we have the law on our side. I think this acceptance of violence to resolve problems is, in part, the reason why we see so much abuse being used to resolve a problem.
>
> Another point I would like to clear up is the comment, 'There is not that much abuse to elderly by their children.' Well, how much is that amount? Can you imagine the headlines tomorrow if it were announced that only 7 percent of the people in this hearing slapped, hit, killed, screamed or threw something at each other? I mean surely that would be astonishing. Or better yet, if it came out in the newspaper that in your latest meeting at church last Saturday or Sunday or whatever night, that only 4 percent of the church members hit each other. You would think that was outrageous, and yet when it happens in the family setting it is not looked at as bad.

Jim Bergman again made the point of the importance of mandatory reporting laws which also give immunity from suit to the reporter. He said:

> There is no question that we have barely touched the surface of elder abuse cases. South Carolina's experience, and Connecticut's experience, have shown an immediate leap in the number of reports, once mandatory reporting laws have been passed and implemented. I think Connecticut in the first year that it was beginning to get its program underway, had approximately 1,100 cases of neglect, exploitation, abuse, or abandonment. In the second year, the numbers are going up higher. There is no question that more reports will come in. A key to that is public information. Immunity for re-

> porters is important; in fact, it is critical. But, public information, just as in spouse abuse cases is the most critical factor because unless people know there is a remedy available, they do not act to protect themselves.

Professor John J. Reagan, Dean of the Hofstra School of Law, Hempsted, New York, testified about the importance of guardianship and protective services for the elderly. He noted that most States lack adult protective service laws and lacked mandatory reporting and immunity provisions. He pointed out that the States and the Federal government must act to help the elderly because they have neither the capacity nor the means to challenge an invasion of rights. He noted that through Title XX of the Social Security Act, the Federal government is already in the business of providing protective services, however, he said it was necessary to adjust regulations under this program to encourage the States to institute adult protective service programs.

R. Bryan Tilley, a legal services developer in the Office on Aging, State of Arkansas, told the Committee about the implementation of Arkansas 1977 adult protective services statute. He said it was expected that his agency would receive about 300 complaints of elder abuse each year but in the first 5 months alone, some 320 cases were received. He estimated that the caseload will run in excess of 1,000 cases each year. Mr. Tilley provided the Committee with several case histories of substantiated abuses.

Elizabeth Lau of the Chronic Illness Center in Cleveland, Ohio also provided case histories. She briefly described the elder abuse study which she completed along with Jordan Kosberg, associate professor of social work at Case Western Reserve University. She noted that initial study was triggered by the revelation that about 10 percent of her adult clients were abused in some way. She said about her study:

> We feel that probably our sample was underreported because we were using case workers' memory to identify those abused persons. Only 15 percent of our people were abused in only one way, 72 percent were abused in two to five ways. We included physical abuse, severe neglect, psychological abuse—including verbal assaults, threats, isolation, and material abuse which we have heard about today called exploitation, theft, or misuse of money, belongings, or property. Others had their rights violated by being forced to move from their residence to a nursing home or other residence.

Ms. Lau endorsed the same remedies as several other witnesses: mandatory reporting of suspected abuses; immunity from suit for those persons required to report abuses; and a Statewide system with capability to launch immediate investigations and to provide services to the abused aged.

Mary Hill, assistant administrator of the Century Home in Baltimore, Maryland was the final witness of the day. She described a kind of financial abuse which occurs in nursing homes. Most Medicaid patients receive $25 a month in a personal spending allowance. Upon entering a nursing home, the patient will decide who is to control this money. In most cases, relatives are asked to do so. In the case where an individual is not competent, his or her money is collected by representative payees. Mrs. Hill described examples of families who unfortunately are not using this money for the benefit of the patient—they are converting the money to their own use.

In summary, these four hearings again emphasized the growing importance of the problem of elder abuse and pointed out that it has not been addressed effectively in all but a few States. The hearings reinforced the need for legislative action at both the State and Federal level and began to provide some consensus as to the shape that such reforms might take.

VII. SUMMARY AND CONCLUSIONS

The evidence accumulated by the Committee in the course of this first national investigation into the topic of elder abuse leaves little doubt about the serious nature of the problem. It is widespread and it is growing. The case histories in Section I of this report do not make pleasant reading. No one likes to think that children and caregivers sometimes strike their elderly parents or wards or threaten them at gun point to yield their meager social security checks. No one likes to think that the senior parents sometimes are being deprived of their basic constitutional rights or that they are being psychologically assaulted by their loved ones. However, the shocking facts must be faced. These and other abuses do occur and with a frequency that few have dared to suggest.

The case histories provided in Section I are shocking in isolation but their accumulated weight is devastating. The effect of these examples is amplified by the fact that hundreds of similar cases can be found in files of the Select Committee on Aging. The suggestion is that the examples contained herein are typical rather than a selection of the most horrible cases which can be found. Further amplification is provided in the statements of adult protective service workers who suggest that thousands of additional cases exist in the community waiting to be discovered. The Committee was impressed with the number of such workers who spontaneously and independently used the phrase "the tip of the iceberg" to describe the number of elder abuse cases discovered in their States.

As noted in Section II of this report, there are at least 14 different categories of support for the Committee's conclusion that elder abuse is a widespread serious and growing problem. The Committee's hearings, of course, are a prime source of support for the conclusions which are stated in this report. The hundreds of letters and cases received by Members of Congress and referred to the Committee on Aging are another source. The Committee's questionnaires to 30 police chiefs, to home health agencies and to State Protective Service Departments add reinforcement, as do newspaper exposes and numerous studies by universities. The testimony and hearings before State legislative committees, Grand Jury investigations and investigations by the U.S. Postal Service all help to create the picture of a desperate problem which can no longer be ignored.

While it is not comfortable for Americans to admit that abuse of the elderly by their loved ones exists at any level, the facts cannot be ignored. The data assembled in this report has served to provide a fairly good portrait of the people who are likely victims of elder abuse and of those most likely to perpetrate it. We know, for example, that most incidents of abuse are recurring events rather than single occurrances. The victims are likely to be very old, age 75 or older. Women are more likely to be abused than men. The victims are generally in a position of dependency—that is, they are relying on others (and generally on those who abuse them) for care and protection. It appears that physical abuse including negligence is the largest category accounting for one-third of all cases followed by financial abuse which accounted for about one-quarter of all cases. The categories of violation of rights and psychological abuse followed, however, numerous cases were found where all four of these categories were represented.

It seems clear that victims seldom report cases of abuse to the authorities. More than 70 percent of all cases were reported by third parties. The elderly who are abused are often ashamed or may not want to bring trouble to their children or they may fear reprisals if they complain. Some seniors do not have the physical ability or sometimes have been deprived of the opportunity to register complaints by one means or another even if they wished to do so. Even with the limited resources at their disposal, the States have confirmed that at least 50 percent of the complaints about elder abuse are substantiated, while 30 percent were not and the remainder were inconclusive. This suggests that complaints of a frivolous nature are not a common phenomenon.

The likely abuser will undoubtedly be experiencing great stress. Alcoholism, drug addiction, marital problems and long-term financial difficulties all play a part in bringing a person to abuse his or her parents. The son of the victim is the most likely abuser accounting for about 21 percent of all instances, followed by the daughter of the victim in about 17 percent of all cases. Third in line was the spouse of the victim when acting in a caregiving role, with the male spouse slightly more likey to be the abuser than the abused. It is also interesting to note that those who were abused by their parents as children are more likely to abuse their aged parents.

The theories concerning why elder abuse exists are likely to be debated by social scientists for years to come. The Committee could not find any one single answer. However, a few generalizations appear to be possible beyond pointing to stress as a common denominator. To some degree, the problem has been caused by modern antibiotics which have been developed since the Second World War. Modern miracle drugs have had the effect of extending the life span so that more and more people are living longer and longer. However, those who live longer suffer from an increasing number of mental and physical disabilities. Those who would have died twenty years ago are living today but they require tremenodous amounts of medical and supportive services.

In other words, the phenomenon of large numbers of disabled, frail individuals of advanced age is a new one on the American scene. Combining this factor with declining birth rates and galloping inflation leads to the conclusion that fewer and fewer people are going to be supporting more and more elderly disabled relatives and having a tough time doing it. This is particularly true in as much as expenses associated with caring for parents in their advanced age generally coincide with the costs of college education for one or more children.

Environmental factors and the lack of community resources both play a part in creating a climate in which the abuse of the elderly exists. Both factors point to the fact that the United States has developed no consistent, comprehensive policy with respect to the treatment of the infirm elderly. Family members which wish to care for their loved ones at home received no help from the State or Federal government. Those who neglect their familial duties are rewarded by having the Medicaid program intervene to care for their loved ones. Moreover, the Medicaid program can be indicted on the grounds that it attaches the stigma of social worthlessness to those who accept its benefits and because of the program's bias in favor of institutionalization instead of home health care alternatives.

In addition to all the above there inevitably will be factors of personality which enter into the equation. Some old people are simply not very pleasant to be around. The same can be said for some young people. Through whatever accident of gentics or environment there will always be those who will provide provocation and those that will strike out with or without provocation. There are some old people who continue to threaten their middle-aged offspring as infants which sparks resentment and there are some offspring that infantilize or patronize their parents. Inevitably, in many families there will always be individuals interacting at various ages who seem to be on a collision course. When this happens, generally one of the family members eases the tension by leaving home. In the case of young adults, this solution works out fine but there is no similar escape available either to the infirm elderly who are in a dependent position, nor is there any escape for the people they depend upon.

From the evidence collected in this report and from the experience in the study of child abuse it would seem safe to offer yet another generalization. Domestic problems in general increase whenever the family experiences financial problems. In times of high unemployment and high inflation, the incidence of elder abuse, like the incidence of child abuse, spouse abuse and violent crime, will continue to increase. It is, therefore, extremely important that measures are undertaken to deal with the problem before it mushrooms.

This leads us to draw some conclusions about the performance of the States. As noted in Section IV, the States are just beginning to recognize the importance of the problem. The average State spent $679,254 for adult protective services specifically to senior citizens as contrasted with an average of $12.6 million for child protective services. It is true that there are 2½ times more children in the United States than there are senior citizens which suggests that at least one-third of State protective services monies should be allocated to the elderly. In point of fact, the average State has committed 86.77 percent of its budget to children and 6.60 percent to senior citizens with the remainder going to provide protective services to adults between the ages of 18 and 64. This is a serious and unjustified balance.

The above comparison between child abuse and adult abuse would not be complete without some effort to compare the incidence of each. As noted in Section IV, the Committee collected the data for 10 States learning that one out of six elder abuse cases are reported as contrasted with one out of every three child abuse cases. In these 10 States, which had approximately 10,000,000 children under age 18 and 4,340,500 over the age of 65, the Committee developed actual reported and estimated unreported cases for both segments of the population in 1980. It was this computation from 10 States which was projected to the nation in general to reach the supportable conclusion that 4 percent of the elderly population may be victims of some form of elder abuse from moderate to severe. The same computation suggests that the incidence of abuse for children is higher at 6.8 percent. In short, elder abuse does not appear to exist with the numerical frequency of child abuse (nor should it since there are 2½ times more children than seniors) nor is the incidence of abuse as high. Nevertheless, elder abuse is obviously a more hidden problem since fewer cases are reported and there is no one who will quarrel with the statement that the potential abuse of one million people, or 4 percent of the entire senior citizen population, is a problem of staggering dimensions.

The analogy to that much maligned institution, the American nursing home, again provides perspective. If the Committee's figures have validity, the conclusion is that the potential abuse of the elderly by their loved ones in their own homes comes close to equalling the entire census of American nursing homes on any given day in 1981. While turnover of some patients in nursing homes complicates matters, it is enough to say that a level of physical, financial and psychological abuse exists among the elderly who live at home with their caregiving dependents which may equal or exceed the levels of real or perceived abuse in nursing homes. It was instructive to note that in case after case the abused elderly either at their own initiative or more likely at the instance of caseworkers, were removed to the comfort, care and safety of a nursing home. This may suggest either that the quality of nursing home care has greatly improved over the past few years or that by comparison they offer a more therapeutic less punitive atmosphere.

The data in this report also leads to the conclusion that there is some room for the Federal government to act to help the States provides protective services to their senior citizens. Federal legislation in the area of child abuse has paid handsome dividends compared to the paucity of effort which preceded the enactment of the Child Abuse Prevention and Treatment Act of 1974. It seems obvious that the Federal government could play a similar role in the analogous area of elder abuse.

The Congress must act in order to help the States and stimulate them to improve their own statutes and the protections they offer the infirm and dependent e'derly. The alternative is that the number of gross abuses as so graphically reported in Section I of this report will increase at a rapid pace. The decision to take action may have a lot to say about how future generations will judge the greatness, the spirit and the values of American civilization.

VIII. POLICY ALTERNATIVES

It is apparent that a coordinated attack on several fronts is necessary if there is to be any hope of limiting the number of elder abuse cases in the future. Obviously, the problem is so widespread and runs so deep that it can never fully be eliminated. However, because so little is being done at the present time at either the State or the Federal level, even a modest reform effort can have significant and far-reaching results.

The basic recommendation of this report is that the Federal government should assist the States in their efforts to deal with the pervasive problem of elder abuse. This need not involve tremendous new expenditures of Federal funds. For example, the Child Abuse program after which one Federal reform effort is patterned has had a salutary effect in encouraging the States to deal with child abuse at an expenditure in 1974, when the program first started, of $4.5 million annually to $22.9 million today. Moreover, it is obvious that the Federal government can do much at no cost by removing technical impediments in the law or by reversing incentives in Federal programs such as Social Security, Supplemental Security Income, Medicare, Medicaid, and Title XX, which presently serve to break down the extended family and create the climate which fosters abuse of the elderly.

A number of different approaches are suggested below. These options are not necessarily mutually exclusive. Federal options are listed first, followed by policy alternatives for the consideration of State and local governments, and finally a third category of recommendations for action in matters tangential to elder abuse which the Committee discovered in the course of this study.

A. FEDERAL OPTIONS

State advocates of Federal involvement in the area of protective services for elders suggest that one way to encourage States to make the statutory and administrative changes would be to make Federal funding for elder abuse-related programs contingent on certain State-level requirements. The Child Abuse Prevention and Treatment Act uses this approach in distributing funds to the States for child-abuse related programs, and almost every State has come into compliance with the requirements. The proposed Prevention, Identification, and Treatment of Elder Abuse Act of 1981 uses this method to encourage States to modify their elder abuse-related laws and procedures. This would be an important step in controlling unwarranted violence against the aged. Therefore:

1. **The Congress may wish to enact H.R. 769, the Prevention, Identification and Treatment of Elder Abuse Act of 1981. This bill would create a National Center on Adult Abuse under the Secretary of Health and Human Services to compile, publish, and disseminate information about programs and special problems related to adult abuse, neglect, and exploitation; and conduct research into the causes, prevention, treatment, and national incidence of adult abuse, neglect, and exploitation. The bill would also provide assistance to States which provided for the reporting of known and suspected incidences of elder abuse, neglect, and exploitation; have in effect a law which provides for immunity from prosecution for persons reporting incidences of abuse, neglect, and exploitation; provides that upon receipt of such a report an investigation will be initiated and steps taken to protect the abused, neglected or exploited adult; have in effect administrative procedures, trained personnel, institutional and other facilities, and multi-disciplinary programs and services to deal effectively with the special problems of elder abuse, neglect, and exploitation; provides for the confidentiality of records; provide for the cooperation of law enforcement officials, courts, and appropriate agencies providing human services, with respect to special problems of adult abuse, neglect, and exploitation; provides that the least restrictive alternatives are made available to the abused, neglected or exploited adults; and provides that the abused, neglected, or exploited adult participate in decisions regarding his/her welfare.**

Experts and State officials almost universally agree that the provision of more social services to families who are caring for an older person is essential. They contend that more home health services, personal services such as bathing and dressing the older persons, homemaker services, home-delivered meals, adult day care, and respite care (short-term total care), would help lessen the family stress that can result from constantly responding to the needs of a dependent family member. To accomplish this, therefore:

2. **The Congress may wish to amend Title III of the Older Americans Act to require the States to give priority to families with dependent elderly members when alloting access, legal and in-home services.**
3. **The Congress may wish to amend Title XX to liberalize the income eligibility level for caretaking families. At the present time, eligibility for a wide variety of social services is limited to SSI and AFDC recipients, individuals, and families who have incomes less than 115 percent of the State's median income, adjusted for family size. This criterion alone excludes many families who, despite their ineligibility, may not be able to afford these services on their own.**
4. **The Congress may also with to amend Title XX to include emergency shelter for elders as a protective service. As the law is now written, protective services can include emergency shelter for children, but neither the law nor the regulations provide for emergency shelter for elders.**
5. **The Congress may wish to amend the Supplemental Security Income Program (SSI) to require that benefits not be reduced when eligible individuals are living in the household of another individual and receiving support or in-kind maintenance from that person.**
6. **The Congress may wish to amend the Medicare and Medicaid programs to eliminate the limitations placed on benefits and services to elderly persons who live at home and are cared for by family members. In addition, Congress may wish to amend Medicare so that senior citizens could elect to be covered for expenses of day care in lieu of some of their home health care benefits currently authorized by law.**
7. **The Congress may wish to consider the enactment of certain tax incentives to encourage families to care for their elderly in their own homes, such as tax credits to those who care for a dependent older family member in their own home, or a tax credit for those who adapt or expand their homes to accommodate a dependent person.**
8. **The Congress may wish to consider authorizing respite care as reimburseable under the Medicare program. Payment could be authorized for a two-week stay in a nursing home each year for senior citizens who are certified as in need of medical nursing care, supportive services and 24-hour supervision. This would provide relief for family members who are making the effort to care for their loved ones at home.**
9. **The Legal Service Corporation Act could be amended to permit legal assistance to be provided for elders who have been physically abused in private homes rather than licensed institutions. At the present time, legal services provided by the corporation are restricted to civil matters.**

B. STATE AND LOCAL OPTIONS

In the area of State law, the most important change, according to many experts, would be provisions for mandatory reporting of suspected abuse, prompt investigation by a designated State agency, and immunity from prosecution for those who report. All 50 States have laws of this type relating to child abuse, but only 16 States have mandatory reporting laws for suspected instances of adult abuse.[1] Therefore:

10. **The States may wish to consider enacting legislation incorporating the provisions included in H.R. 769, the proposed "Prevention, Identification and Treatment of Elder Abuse Act of 1981," as introduced in the U.S. Congress.**

Other needed changes in State laws, according to those familiar with the area, include more specific tailoring of civil remedies, such as restraining orders and vacate orders, and social services such as emergency shelter, to situations involving sometimes frail, nonambulatory elderly persons living with relatives. Better coordination of State-level programs, including social and protective services, legal aid programs, and senior citizen-oriented programs, is also viewed as important in detecting and intervening in elder abuse cases.

---

[1] Fowler, Jan. *Domestic Violence: Elder Abuse*, Library of Congress, Congressional Research Service, Education and Public Welfare Division, February 6, 1981, page 6.

Many advocate family counseling before the decision is made to take an elderly relative into the home. Some families may not realize the extent of the demands that will be placed on them when they assume the care of a dependent, sometimes impaired, older person. They may need to be educated as to the physical, emotional, and medical needs of older people and what community services might assist them. It may also be necessary to teach all family members how to interact and solve disputes in nonviolent ways. Therefore:

11. **Families who are considering assuming the responsibility of caring for a dependent older family member may wish to consult with their local area agency on aging to determine what services may be available to assist them in this effort, and thus, reduce many of the stresses associated with caring for an older person unassisted.**

C. RELATED POLICY SUGGESTIONS

A significant number of the abuses perpetrated against the elderly reported by the States occurred in board and care facilities. Boarding homes are a new class of health care facilities that have proliferated following the enactment of the Federal SSI program. Following the enactment in 1972, the States began transferring thousands of mental patients from State mental hospitals to such facilities, placing the residents on the Federal SSI rolls and placing them in boarding homes. One motive was cost savings since it costs the States in excess of $30,000 to provide for an individual in a State mental hospital. Another motive was Supreme Court decisions which required the States either to provide treatment to those involuntarily committed or to release them. At any rate, the result has been that there are more patients in boarding homes than there are in nursing homes. There may be five times as many boarding homes as there are nursing homes. As seen from several fires over the past two years, in which 130 people have lost their lives, many boarding homes are unsafe.

Most boarding homes are converted facilities which were once hotels or nursing homes which could no longer meet fire safety standards. There is evidence that because there are no Federal minimum standards and only sparse State standards, boarding homes now present far greater public health problems than do nursing homes. The House Select Committee on Aging has conducted four hearings on boarding home problems to date. These hearings, as well as the findings in this report, suggest:

12. **That Congress may wish to consider initiating a full-scale national investigation of boarding homes and related problems.**

In both boarding homes and nursing homes, thousands of elderly people have social security, veteran's or other pension checks which are used in part to pay for their board and care. In the case of patients on public assistance (Medicaid) all but $25 a month from these checks is applied to the cost of their stay in the facility. The $25 is reserved as a personal spending allowance. In the case of nonpublic assistance patients, there is often a great deal of money in such checks, which may or may not be turned over to the facility depending on the person's other sources of income. In either case, if a patient cannot manage his or her own money, a representative payee is designated to cash the checks and use the money for the benefit of the patient. Unfortunately, there is abundant evidence that these designated representative payees often do not use the funds for the benefit of the elderly as required by law. Therefore:

13. **The Congress may wish to call upon the U.S. General Accounting Office to determine the extent of this problem and its implications by conducting a study of this matter and to report back to the Congress within a year.**

The White House Conference on Aging, to be held November 30 through December 5, 1981, will address a variety of issues related to the elderly. One emphasis of the Conference is expected to be the relationship of older Americans to their families and the effectiveness of family and community support systems. Therefore:

14. **The Congress may wish to encourage the Conference to include the issue of elderly abuse on their conference agenda, with attention to be given to an overview of what is now known about the problem, its possible causes, and ways to prevent it.**

IX. APPENDIXES

APPENDIX I

QUESTIONNAIRE ON PROTECTIVE SERVICES FOR THE ELDERLY

There has been a great deal of publicity in recent months regarding the financial, psychological, and physical abuse encountered by older Americans at the hands of their loved ones -- sons, daughters, relatives and caretakers. Some States have responded to this problem by establishing special units within existing departments to respond to complaints of elder abuse. Other States have expanded the coverage of existing adult protective services to include the elderly as in need of services. The purpose of this questionnaire is to gain a better understanding of State activities with respect to protecting victims of elder abuse.

BACKGROUND INFORMATION

1. Does your Department have an office responsible for providing adult protective services and assisting abused adults? ____Yes ____No
If yes, what is the name and address of this office?______________________
____
____

2. What is the age range of adults that are eligible to receive protective services in your State?______________________
____

3. Are these services available to all regardless of income? ____Yes ____No
If no, explain:______________________
____
____

I. BUDGET AND RESOURCES

1. What is the budget for all protective services in your State this year?
$____________________What was it in 1979? $____________

2. Approximately what was the budget for adult protective services provided by the Department this year? $____________________
____________________What was it in 1979? $____________

3. Can you estimate what portion of your budget for adult protective services went toward providing protective services to the elderly in your State this year?______________________%
In 1979?______________________%

4. Approximately what was the budget for child protective services provided by the Department this year? $____________________
____________________What was it in 1979? $____________

5. What is the total number of adult protective service employees (in full time equivalents) hired by the Department?____________
How many are clerical?____________Paraprofessional?________
Professional?______________________

6. What is the salary of the chief of the Adult Protective Service office?
$______________________

7. What is the average salary of the professional adult protective service worker? $______________________

8. What requirements must an individual meet before they can qualify as an adult protective service worker in your State?

Minimum education requirements	____Yes	____No
Minimum Training	____Yes	____No
Prior experience	____Yes	____No
Pass exam	____Yes	____No
Good moral character	____Yes	____No

Is a license required? ____Yes ____No. If yes, which office licenses workers?______________________
____

II. POWER AND DUTIES

1. What are the basic power and duties of the Department with respect to the provision of adult protective services?____________________

   Could you please send us a copy of your State statute together with any summary thereof which you may have?

2. Is there any legislation currently pending consideration in your State which would impact on the provision of adult protective services? ____Yes ____No. If yes, could you please send us a copy of the proposed legislation?

III. ABUSES

1. How many cases of adult abuse came to the Department's attention in 1980?________________In 1979?____________

2. What percentage of these cases involved persons over the age of 65? _______%.

3. How many cases of child abuse came to the Department's attention in 1980?________________In 1979?____________

4. Experts have indicated that many elderly are abused by their children, relatives or caretakers in obvious as well as in subtle ways. The following section of this questionnaire is to ask if you have ever received complaints of any of the following practices:

   A. Physical Abuse - This includes deliberate acts leading to injury of the older person, such as beating, withholding medication, food and personal care necessary for their well-being. This also includes "neglect," such as the excessive use of sleeping medication or alcohol to make the older person who needs constant watching more manageable. ___Yes ___No

   B. Psychological Abuse - This includes verbal assault and threats, provoking fear and isolation. This type of abuse usually preceeds physical abuse. It may involve the threat of unnecessary nursing home placement or various other mistreatments. ___Yes ___No

   C. Material or Financial Abuse - Includes the theft of money or personal property. The appointment of a conservator who does not handle an older person's estate in their best interest. ___Yes ___No

   D. Violation of Rights - This includes being forced out of one's dwelling or being forced into another setting against the older person's will. ___Yes ___No

   E. Other - Explain:____________________

5. Of the elder abuse you encountered this year, how many involved:

   Physical Abuse _____%
   Psychological Abuse _____%
   Financial Abuse _____%
   Violation of Rights _____%
   Other _____%

6. What percentage of the elder abuse cases that came to your attention were substantiated?_________% Unsubstantiated?_________% Inconclusive evidence?_______%.

7. Is it your opinion that a significant number of elder abuse cases go unreported? ____Yes ____No. If yes, what number of cases would you say went unreported in 1980?______________
In 1979?______________

8. Of the elder abuse cases you estimate go unreported, how many would you say involved physical abuse?________% Psychological abuse? ________% Financial Abuse?______________% Violation of Rights?______________%

9. How are complaints of elder abuse brought to your attention?

Investigation initiated by protective service worker ____%
Co-worker ____%
Member of the family ____%
Subject (self report) ____%
Private agencies (Specify)______________ ____%
Public agencies (Specify)______________ ____%
Hospital or clinic ____%
Police ____%
Lawyer ____%
Other ____%

10. Would you say the incidence of elder abuse is increasing?______Yes ________No.

11. Does your Department have standardized forms for reporting elder abuse?____Yes ____No. If yes, may we have a copy?

12. What is the average length of time for resolving elder abuse cases?
____One week ____2 to 4 weeks ____ 5 to 8 weeks ___2-6 months
____Up to a year ____More than a year.

13. What percentage of elder abuse is perpetrated by relatives?______%

In cases where family members or relatives commit such abuse, what percent of them would you guess are perpetrated by each of the following:

Husband ____%
Wife ____%
son ____%
daughter ____%
daughter-in-law ____%
son-in-law ____%
Grandson ____%
Granddaughter ____%
Other relatives (Specify) ____% ______________

14. What percentage of elder abuse is perpetrated by caretakers unrelated to the abused?__________%

In cases where caretakers unrelated to the victim commit such abuse, what percent of them would you guess are perpetrated by each of the following:

Unrelated conservator/guardian ____%
Live in caretaker ____%
Other (Specify) ____%

15. In your opinion, what were the underlying causes which resulted in abuse of the elderly?

Abusive behavior is a response to stress ____%
Abusive behavior is a form of revenge (abuser was abused as a child) ____%
Abusive behavior is a response to lack of community services ____%
Abusive behavior is a response to alcoholic problems ____%
Abusive behavior is a response to psychological problems ____%
Other (Specify)______________ ____%

IV. INTERVENTIONS

1. When an incident of elder abuse is reported, what types of action are most frequently utilized:

	Never	Rarely	Frequently	Always
Notification of Police authorities	_____	_____	_____	_____
Relocation (either temporarily or permanently) of abused or abuser from place where abuse took place	_____	_____	_____	_____
Counselling with those involved	_____	_____	_____	_____
Linking those involved with needed services such as:				
a) Medical	_____	_____	_____	_____
b) Housing	_____	_____	_____	_____
c) Financial	_____	_____	_____	_____
d) Legal	_____	_____	_____	_____
e) Other social services	_____	_____	_____	_____
Other, specify_______________	_____	_____	_____	_____

2. What is the most effective means of intervention, in your opinion?
____

3. Does your agency have written instructions or procedures concerning intervention?____
If so, may we have a copy of them?

4. What barriers make it difficult for you to provide assistance to victims of suspected or substantiated abuse? _______________
____

5. What must be done to make it possible for you to provide assistance to victims of suspected or substantiated abuse?_______________
____

6. To what extent is the general public in your state aware of the problem of elder abuse and the work of your office in this regard?
_____Very Aware _____Modcrately Aware _____Unaware.

V. STATE AND FEDERAL REGULATION

1. Does your state have a law requiring mandatory reporting of elder abuse?
_____Yes _____No. If so, may we have a copy? Also, could you characterize how effective this law is?_______________________________
____

2. Based on your experience, to what extent are the needs of the elderly met through existing state laws or regulations?

Not at all	_____%
Occasionally	_____%
Frequently	_____%
Always	_____%
Do not know	_____%

3. Would you favor Federal legislation to establish model mandatory reporting requirements for elder abuse to be adopted by the States?
_____Yes _____No. If yes, who should be required to report?__________
____
____

4. Enclosed is a copy of our bill, H.R. 7551, "Prevention, Identification, and Treatment of Adult Abuse Act of 1980," and a statement summarizing its provisions. Would you support the passage of this measure?
_____Yes _____No _____Undecided.

VI. REQUEST FOR FURTHER INFORMATION

1. Will you please provide the Committee with typical case histories of elder abuse which have come to your Department's attention? Please feel free to delete names of individuals or protective service employees if you so desire.

2. Has your State produced any pamphlets or literature addressed to senior citizens providing guidance with respect to elder abuse? _____Yes _____No. May we have a copy if such material exists?

3. May we have a copy of your latest annual report?

4. Would you be willing to testify before the House Select Committee on Aging if hearings are once again scheduled on the issue of elder abuse? _____Yes _____No.

5. Is there someone you might suggest we contact for further information on this issue?____

Please return this questionnaire along with additional information and case histories by August 15, 1980.

House Select Committee on Aging
U.S. House of Representatives
3269 House Office Building Annex II
Washington, D.C. 20515

OUR SINCERE THANKS FOR YOUR ASSISTANCE.

APPENDIX II

New York Times Articles on the Mary Ellen Wilson Case, April 10, 11, 14, and 22, 1874 and December 27, 1875.

The case of "Little Mary Ellen," New York, 1874

---

1. Henry Bergh takes the case to court

New York Times, April 10, 1874

Henry Bergh (1811–1888) was founder (1866) and president of the Society for the Prevention of Cruelty to Animals.

MR. BERGH ENLARGING HIS SPHERE OF USEFULNESS Inhuman Treatment of a Little Waif — Her Treatment — A Mystery To Be Cleared Up

It appears from proceedings had in Supreme Court . . . yesterday, in the case of a child named Mary Ellen, that Mr. Bergh does not confine the humane impulses of his heart to smoothing the pathway of the brute creation toward the grave or elsewhere, but that he embraces within the sphere of his kindly efforts the human species also. On his petition a special warrant was issued by Judge Lawrence, bringing before him yesterday the little girl in question, the object of Mr. Bergh being to have her taken from her present custodians and placed in charge of some person or persons by whom she shall be more kindly treated. In his petition Mr. Bergh states that about six years since Francis and Mary Connolly, residing at No. 315 West Forty-first street, obtained possession of the child from Mr. Kellock, Superintendent of the Department of Charities; that her parents are unknown; that her present custodians have been in the habit of beating her cruelly, the marks of which are now visible on her person; that her punishment was so cruel and frequent as to attract the attention of the residents in the vicinity of the Connolly's dwelling, through whom information of the fact was conveyed to Mr. Bergh; that her custodians had boasted that they had a good fortune for keeping her; that not only was she cruelly beaten, but rigidly confined, and that there was reason to believe that her keepers were about to remove her out of the jurisdiction of the court and beyond the limits of the State.

Upon this petition, Judge Lawrence issued, not an ordinary writ of habeas corpus, but a special warrant, provided for by section 65 of the Habeas Corpus act, whereby the child was at once taken possession of and brought within the control of the court. Under authority of the warrant thus granted, Officer McDougal took the child into custody, and produced her in court yesterday. She is a bright little girl, with features indicating unusual mental capacity, but with a care-worn, stunted, and prematurely old look. Her apparent condition of health, as well as her scanty wardrobe, indicated that no change of custody or condition could be much for the worse.

In his statement of the case to the court Mr. Elbridge T. Gerry, who appeared as counsel for Mr. Bergh, said the child's condition had been discovered by a lady who had been on an errand of mercy to a dying woman in the house adjoining, the latter asserting that she could not die happy until she had made the child's treatment known; that this statement had been corroborated by several of the neighbors; that the charitable lady who made the discovery of these facts had gone to several institutions in the vain hope of having them take the child under their care; that as a last resort she applied to Mr. Bergh, who, though the case was not within the scope of the special act to prevent cruelty to animals, recognized it as being clearly within the general laws of humanity, and promptly gave it his attention. It was urged by council that if the child was not committed to the custody of some proper person, she should be placed in some charitable institution: as, if she was to be returned to her present custodians, it would probably result in her being beaten to death.

The Connollys made no appearance in court, and on her examination the child made a statement as follows: My father and mother are both dead. I don't know how old I am. I have no recollection of a time when I did not live with the Connollys. I call Mrs. Connolly mamma. I have never had but one pair of shoes, but I cannot recollect when that was. I have had no shoes or stockings on this Winter. I have never been allowed to go out of the room where the Connollys were, except in the night time, and then only in the yard. I have never had on a particle of flannel. My bed at night has been only a piece of carpet stretched on the floor underneath a window, and I sleep in my little under-garments, with a quilt over me. I am never allowed to play with any children, or to have any company whatever. Mamma (Mrs. Connolly) has been in the habit of whipping and beating me almost every day. She used to whip me with a twisted whip — a raw hide. The whip always left a black and blue mark on my body. I have now the black and blue marks on my head which were made by mamma, and also a cut on the left side of my forehead which was made by a pair of scissors. (Scissors produced in court.) She struck me with the scissors and cut me; I have no recollection of ever having been kissed by any one — have never been kissed by mamma. I have never been taken on my mamma's lap and caressed or petted. I never dared to speak to anybody, because if I did I would get whipped. I have never had, to my recollection, any more clothing than I have at present — a calico dress and skirt. I have seen stockings and other clothes in our room, but was not allowed to put them on. Whenever mamma went out I was locked up in the bedroom. I do not know for what I was whipped — mamma never said anything to me when she whipped me. I do not want to go back to live with mamma, because she beats me so. I have no recollection of ever being on the street in my life.

At this point of the investigation, and adjournment was taken until 10 o'clock A.M., to-day.

In addition to the foregoing testimony, Messrs. Gerry and Ambrose Monell, counsel on behalf of the application, stated in court that further evidence would be produced corroborating the statement of the child as to the cruelty and neglect which she has sustained; also, as to the mysterious visits of parties to the house of the Connollys, which, taken together with the intelligent and rather refined appearance of the child, tends to the conclusion that she is the child of parents of some prominence in society, who, for some reason have abandoned her to her present undeserved fate.

Before adjournment the child was removed into the Judge's private room, where, apart from all parties to the proceedings, she corroborated before Judge Lawrence her statement as herein given. Counsel on behalf of Mr. Bergh, in his statement to the court, desired it to be clearly understood that the latter's action in the case has been prompted by his feelings and duty as a humane citizen; that in no sense has he acted in his official capacity as President of the Society for Prevention of Cruelty to Animals, but is none the less determined to avail himself of such means as the laws place within his power, to prevent the too frequent cruelties practiced on children.

In ordering the adjournment, Judge Lawrence said he would direct a subpoena to issue for the woman who has the child in charge, as, he said, he had no doubt she could disclose the names of one or both of the child's parents, and he desired to be informed on that point before making a final disposition of the child's custody.

---

2. How Mrs. Connolly obtained Mary Ellen Wilson

New York Times, April 11, 1874.

THE MISSION OF HUMANITY

Continuation of the Proceedings Instituted by Mr. Bergh on Behalf of the Child, Mary Ellen Wilson

Proceedings in the case of Mary Ellen Wilson, the little girl of eight years, charged to have been cruelly treated by Francis and Mary Connolly, of No. 315 West Forty-first street, an account of which appeared in The Times of yesterday, were continued yesterday, before Judge Lawrence, in Supreme Court, Chambers. Quite a number of persons, including several ladies, were attracted to the court by the publicity which had been given to the proceedings had on the previous day, all of them evidently deeply sympathizing with the little neglected waif, whose cause had been espoused by Mr. Bergh. Ten o'clock in the morning, to which the hearing had been adjourned, found the little girl, Mr. Bergh and his counsel, Messrs. Elbridge T. Gerry and Ambrose Monell, and Mrs. Connolly, the former custodian of the girl, all present in court. The first witness put upon the stand was Mrs. Connolly, who testified as follows: I was formerly married to Thomas McCormack, and had three children by him, all of whom are dead. After Mr. McCormack's death I married Francis Connolly. Before my first husband died he had told me he had three children by another woman, who was alive, but was a good-for-nothing. I went with McCormack to Mr. Kellock, and got out the child, Mary Ellen, my husband signing the paper.

Here the paper referred to was produced, and which proved to be an "indenture" of the child, Mary Ellen Wilson, aged one year and six months, to Thomas McCormack, butcher, and his wife, Mary, in February, 1866, and whereby they undertook to report once a year the condition of the child to the Commissioners of Charities and Correction. This indenture was indorsed by Commissioner Isaac Bell and Secretary Brown.

Witness continued as follows: I know this was one of my husband's illegitimate children. He selected this one. The mother's name, I suppose, is Wilson, because Mr. Kellock, the Superintendent, had the name down. Mr. Kellock asked no questions about my relation to the child. I told him I wanted this child. My husband never told me where the woman Wilson lived. We got the child out on the 2d of January, without any paper being served or any receipt for the child. This was the only paper we signed, and it was not signed until the 15th of February. Sometimes my husband told me the mother of the child lived down town. I learned from several people who knew my husband that the woman is still alive. I could not tell who they were. They were laborers who came from work with him and stopped there drinking. I have no way of knowing if the woman is still alive, or if she has any relatives. I never received a cent for supporting this child. At the time I took the child we were living at No. 866 Third avenue, and my husband said the mother left it there, and he would take it out until such time as she called for it. I have instructed the child according to the undertaking in the indenture — that there is a God, and what it is to lie. I have not instructed her in "the art and mystery of housekeeping," because she is too young. She had a flannel petticoat when she came to me, and I gave her no others.

At this point the witness grew somewhat excited at Mr. Gerry, the examining counsel, whom she assumed to be ignorant of the difficulties of bringing up and governing children, and concluded her testimony by an admission that on but two occasions had she complied with the conditions of the indenture requiring her to report once a year to the Commissioners of Charities and Correction the condition of the child.

New York Times, April 14, 1874.

Mr. Geo. Kellock, Superintendent of Outdoor Poor, testified that a child named Mary Ellen Wilson was indentured from the Department of Charities in 1866, being then eighteen months old; that the records show the same to have been left there on the 21st of May, 1864, by a woman named Mary Score, giving her address as No. 235 Mulberry street, and who swore that until within three weeks of that time she had received $8 per month for the child's support; had no means of knowing who the child's parents were, and nothing was said by either Mr. McCormack or his wife, Mrs. Connolly, at the time, as to any relationship of either of them to the child; the $8 per month had been paid to Mary Score by the parties leaving the child with her, and it was when that payment stopped that she brought the child to his office. Reference was demanded from Mr. and Mrs. McCormack when they took the child, and they gave their family physician, Dr. Laughlin or McLaughlin, whose statement in reference to them was deemed satisfactory, and an order for the delivery of the child was given accordingly; believes he can find Dr. Laughlin, who lived in the vicinity of Twenty-third street and Third avenue. During the past year about 500 children have passed through the department, and witness has no recollection of this one other than the records of his office record. At this point the further hearing was adjourned to Thursday morning next, at 10 o'clock A.M.

---

3. Mrs. Connolly found guilty of felonious assault

New York Times, April 22, 1874.

MARY ELLEN WILSON

Mrs. Connolly, the Guardian, Found Guilty, and Sentenced One Year's Imprisonment at Hard Labor

Mary Connolly, the discovery of whose inhuman treatment of the little waif, Mary Ellen Wilson, caused such excitement and indignation in the community, was placed on trial before Recorder Hackett yesterday, in the Court of General Sessions. The prisoner, whose appearance is anything but prepossessing, sat immovable during the proceedings, never lifting her eyes from the ground, except when the child was first placed on the stand. Little Mary Ellen, an interesting-looking child, was neatly dressed in the new clothes provided for her by the humane ladies who have taken an interest in her, and has so much improved since her first appearance in the courts as to be scarcely recognized as the cowering, half-naked child rescued by Mr. Bergh's officers. The child was brought into court in charge of Mrs. Webb, the matron at Police Headquarters. Mr. Bergh occupied a seat beside District Attorney Rollins, and took an active part in the proceedings. There were two indictments against the prisoner, one for feloniously assaulting Mary Ellen Wilson with a pair of scissors on the 7th of April, and the other for a series of assaults committed during the years 1873 and 1874. The trial yesterday was on the indictment charging felonious assault.

The little child was put upon the stand, and having been instructed by Recorder Hackett in the nature and responsibility of an oath, was sworn. At first she answered the questions put to her readily, but soon became frightened and gave way to sobs and tears. She was soon reassured, however, by the kind words of the Recorder and District Attorney Rollins, and intelligently detailed the story of her ill-treatment. The scar on her forehead when taken from Mrs. Connolly's house, had been inflicted, she said, by her "mamma" with a pair of scissors. Her "mamma" as she called Mrs. Connolly, had been ripping a quilt, which she held, and struck her with the scissors because she did not like how the quilt was held. The child stated that she had been repeatedly beaten with a long cane by her "mamma" without having done anything wrong. The general cruelty and neglect of Mrs. Connolly were also testified to by the child, as has already been published in the proceedings of the preliminary examinations. Mrs. Webb, Matron at Police Headquarters, Detective McDougall, Alonzo S. Evans, of Mr. Bergh's society, Mrs. Wheeler of St. Luke's Mission, Mrs. Bingham, from whom the prisoner rented apartments, Mrs. States, and Charles Smith, testified to the bruises and filth on the child's body when rescued from Mrs. Connolly's, and to the instances of ill-treatment which had come to their knowledge. After an able argument from District Attorney Rollins and a charge of characteristics clearness from the Recorder, the jury retired, and after twenty minutes deliberation, returned a verdict of guilty of assault and battery.

Recorder Hackett, addressing the prisoner, said that he had no doubt whatever of her guilt. She had been accorded every opportunity to prove her innocence, and the court was fully satisfied that she had been guilty of gross and wanton cruelty. He would have been satisfied if the jury had found her guilty of the higher offense charged. As a punishment to herself, but more as a warning to others, he would sentence her to the extreme penalty of the law — one year in the Penitentiary at hard labor. The prisoner heard her sentence without moving a muscle, and preserved the same hard, cruel expression of countenance displayed by her during the trial, while being conveyed to the Tombs.

A brother of Mrs. Connolly says that the child was legally adopted by the prisoner, who has the legal proofs in her possession, and will seek to gain the custody of the little one at the expiration of her term of punishment.

---

4. Mary Ellen sent to an asylum

New York Times, Dec. 27, 1875

LITTLE MARY ELLEN FINALLY DISPOSED OF

In the matter of the child Mary Ellen Wilson, rescued from Mary Connolly, and whose grandparents were alleged to be residing in London, Judge Lawrence yesterday decided that the relatives not having been found, the child should be sent to "The Sheltering Arms." It was the case of little Mary Ellen which led to the formation of the Society for the Prevention of Cruelty to Children.

New York Society for the Prevention of Cruelty to Children

---

1. The Society is organized, December, 1874

New York Times, Dec. 17, 1874

Elbridge T. Gerry (1837–1927), lawyer and philanthropist, was legal advisor to the American Society for the Prevention of Cruelty to Animals and served as president of the New York Society for the Prevention of Cruelty to Children from 1879 to 1901.

The apprehension and subsequent conviction of the persecutors of little Mary Ellen, some time since, suggested to Mr. Elbridge T. Gerry, the counsel engaged in the prosecution of the case, the necessity for the existence of an organized society for the prevention of similar acts of atrocity. Upon expressing his views among his friends he found plenty of sympathizers with the movement, but no one sufficiently interested to attempt the formation of such a society. About this time he met Mr. John D. Wright, to whom he stated his plan. The latter at once became warmly interested, and undertook the necessary steps toward effecting an organization. Invitations were extended to a large number of prominent citizens interested in the welfare of children to meet at Association Hall on Tuesday afternoon and many promptly responded. Mr. Gerry defined the object of the meeting which, he said, was to organize a society for the prevention of cruelty to children. There were in existence in this City and State, he said, many excellent institutions, some as charitable corps, and others as State reformatories and asylums, for receiving and caring for little children. Among these ought be cited the Children's Aid Society, Society for the Protection of Destitute Children, etc., and in addition each religious denomination had one or more hospitals and similar institutions devoted to the moral and physical culture of helpless children. These societies, however, only assured the care of their inmates after they had been legally placed in their custody. It was not in the province of these excellent institutions to seek out and rescue from the dens and slums of the City the little unfortunates whose lives were rendered miserable by the system of cruelty and abuse which was constantly practiced upon them by the human brutes who happened to possess the custody or control of them; and this was the defect which it was proposed to remedy by the formation of this society. There were plenty of laws existing on the statute books of the State, which provided for all such cases as had been cited but unfortunately no one had heretofore been held responsible for their enforcement. The Police and prosecuting officers were engaged in the prosecution and conviction of offenses of a graver legal character, and, although they were always ready to aid in enforcing the laws when duly called upon to do so, they could not be expected to discover and prosecute those who claimed the right to ill-treat the children over whom they had an apparent legal control. This society proposed to enforce legally, but energetically, the existing laws and to secure the conviction and punishment of every violation of any of those laws. The society would not interfere with the numerous institutions already existing, but would aid them in their work. It did not propose to aid any religious denomination, and would be kept entirely free from any political influences. Its duty toward the children would be discharged when their future custody should be decided by the courts. The counsel for the society volunteers his gratuitous services in the prosecution of cases reported by its officers during the first year. The Secretary will be entitled to a moderate compensation, but no salary will be paid to the remaining officers.

. . . . .

The Secretary will be provided with a book in which all parties who desire to enroll themselves as members may do so at the office of the society, which will be located temporarily in the office of the Society for the Prevention of Cruelty to Animals, No. 100 East Twenty-second Street. The first annual meeting of the society will be held on December 28, 1875.

APPENDIX III

Detroit News Articles, Congressional Record, May 22, 1969

to the vehicle, the driver and a passenger perishing in the flames. Senseless? Probably not, in the Viet Cong view.

"The bus was probably owned by a Chinese businessman," says the analyst. "Now every commercial vehicle moving on the roads in Vietnam pays 'taxes' to the VC or to crooks who claim they are VC. The Chinese are pretty foxy, the businessman probably tried to get out of paying off."

Adding to the terror mix are straight forward attacks upon targets such as police stations and military installations in which innocent bystanders are inevitably killed and wounded. Terrorists casually wheeled a cart up to a police station in Cholon at midday last week and fled when suspicious policemen approached. Seconds later, a 40-pound explosive in the cart ripped through the police station, killing one woman and wounding 36 bystanders.

Another nervy terror squad was surprised in the process of setting up a 60mm. mortar in a school house within range of the heavily guarded Presidential Palace. National police killed one of the mortar-men and arrested two others.

SENSELESS ACTS

Regardless of the rationale, Westerners find many acts of terrorism "senseless" in view of the extremely heavy toll of innocent persons. Terrorists one recent morning concealed a powerful bomb in a container and placed it on a street corner in front of a coffee shop in the most congested section of the market in Ben Tre, a city south of here. The bomb killed 6 persons and wounded 42; among the dead were two 60-year-old women and two girls, aged 3 and 12.

Equally horrible, in Western eyes, are the indiscriminate rocketings of market places, hospitals, and shacks of the poor in cities such as Saigon and Da Nang. Such actions are seen as attempts at mass terrorization. They fail because the enemy is not strong enough to send rockets and mortars over in sufficient quantity to induce this effect. As a result, the rocketings have had a tendency to backfire, infuriating many people who had often as not been indifferent to either the Viet Cong or the government. The rocketings have even converted some opponents of the Thieu government.

"Some militant Buddhists came to me in shocked surprise and righteous indignation," says one U.S. official. "They said, as though they had just discovered a great new truth: 'Why, they are killing innocent people with these rockets here in Saigon!' It was all I could do to keep from replying: 'Yes, you're at least getting a dose of what the people in the villages have been living with for nearly 15 years. Maybe now you'll wake up.'"

By far the most grisly, and significant, chapter in th history of Viet Cong and North Vietnamese terrorism in South Vietnam is still unfolding in the city of Hue where, since the end of the Tet offensive last year, more than 2,000 bodies of persons methodically assassinated by the enemy have been dug up from shallow mass graves. Volunteer grave-diggers, many of them teen-agers, are still finding bodies, and officials believe that another 1,000 and possibly 3,000 will be uncovered.

"It was the beginning of the 'night of the long knives' that is standard operating procedure after a Communist takeover," says a U.S. State Department man who has made a study of the Hue massacre. "The North Vietnamese held Hue for nearly a month, and they had planned to hold it permanently as an enclave. The assassination squads worked from prepared lists, just as the Nazis and the Stalinists did. What happened in Hue is just a smattering of what you can expect if the Communists succeed in taking over South Vietnam."

There is reason to believe that President Nixon had Hue in mind when he said in his Vietnam speech last week: "When we assumed the burden of helping defend South Vietnam, millions of South Vietnamese men, women, and children placed their trust in us. To abandon them now would risk a massacre that would shock and dismay everyone in the world who values human life."

When the enemy was finally dislodged last year from the thick-walled Citadel of Hue where they made their last stand, 19 mass graves were found containing the bodies of 1,200 men, women, and children. Many of the dead were the usual victims: city and province officials, national policemen, military personnel, others with a reputation for anti-communism, and Catholic refugees from North Vietnam.

NEW TURN ON THEIR ALLIES

But what came as a shock to many was the fact that the Communists also assassinated militant Buddhists who had been involved in earlier attempts to overthrow the Saigon regime, men who had worked with the Communists toward this end. They eliminated, as well, members of numerous antigovernment political parties, foreign missionaries, and medical personnel.

Among the foreigners killed were Father M. Cressonier, 59, and Father Pierre Poncet, 36, of France, who belonged to the Societe des Missions Etrangeres de Paris, Father Cressonier having lived in Hue for 25 years. Two other French priests, members of the Benedictine Order, were also assassinated.

Students and faculty of Hue University were appalled at the murder of three German professors of medicine and the wife of one of them.

"They were discovered April 2, 1968," says a U.S. Government report. "They had been dumped into a single shallow grave in a freshly plowed potato field behind a rural pagoda not more than 1½ kilometers south of the walled city. All had been shot in the back of the head, their hands trussed behind them with wire. The victims were: Dr. Horst Krainick, 60, professor of pediatrics, and his wife Elisabeth (whose body had been mutilated); Dr. Raimund Discher, 44, professor of internal medicine, and Dr. Alois Altekoester, 36, professor of general medicine.

"These people had never done anything warlike or hurtful to the VC," said Dr. Nguyen The Anh, professor of history and rector of Hue University. "And Frau Krainick was a gracious lady. We simply don't understand it."

BURIED ALIVE

American and South Vietnamese investigating teams report that "almost half of the victims were found in conditions indicating that they had been buried alive. Many were found together in groups of 10 to 15, eyes open, with dirt or cloth in their mouths. Evidence also was discovered of victims having been clubbed unconscious prior to being buried alive."

In one official report of the massacre there appears this item: "Tang Quang Tu Pagoda. Coordinates: YD 764-240. Number of graves: 13. Number of bodies: 67. Date discovered: From 3/1/68. Comment: Victims shot. Buddhist monk in Pagoda heard nightly executions by pistol and rifle shots in plowed field behind pagoda during first two weeks in February, with victims pleading for mercy. Leader of Vietnam Nationalist Party Nguyen Ngoc Ky, was among victims found here."

In March of this year, a new search for bodies was begun at the instigation of a diminutive 40-year-old widow, Madame Ton That Lang of a neighboring district. Her husband, a school teacher, had been taken from their home by six Viet Cong soldiers six days after the city's occupation.

Madame Lang prevailed upon her district chief to ask for volunteers and trucks to begin a search for bodies in the sandy marshlands not far from Hue. The search was successful. Other committees were formed, other searches were begun, more bodies were found.

"One set of graves was discovered when someone noticed that the grass in that particular field was greener than it was in the next field," says an American official.

Identification, most of the time, has been impossible, for the enemy destroyed the victims' identification cards. One woman obviously had a premonition of her fate: She wrote her name, ID card number, and address in ink on the inside of her underwear.

The first batch of 1,200 bodies found last year was buried in a paddy. But the new finds, totaling 800 bodies so far, are so numerous that it was decided not to waste any more valuable rice-growing land with a cemetery, hence a new burial ground has been established in sandy scrubland.

The bodies are placed in plywood coffins, which are painted red and given numbers. Then mass funerals are held. Among the mourners at a recent funeral was Madame Lang. She hasn't found her husband's body yet. But she hasn't given up the search.

MICHIGAN'S BATTERED BABIES

HON. MARTHA W. GRIFFITHS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, May 22, 1969

Mrs. GRIFFITHS. Mr. Speaker, the Detroit News recently carried a series of articles written by Ruth Carlton and Kathleen O'Brien on Michigan's battered babies. The tragedy of child abuse with its unbelievable horrors points to an area where there is great need for new approaches by the courts, welfare agencies, and the entire community toward solving this problem. In Michigan last year the reported number of child abuse cases totaled 766, and for the Nation as a whole it is reported that one or two children are killed by their parents every day.

Indeed, too little attention has been given to the innocent victims involved, many of whom are too young to talk and are forced to bear lifelong emotional and physical scars of this brutality. One of the reasons this problem has been overlooked is that it relates to the family and the personal relationship of its members. But this whole problem affects society and it demands solution.

At this point, I place the series in the CONGRESSIONAL RECORD for everyone to read:

MICHIGAN'S BATTERED BABIES: ARE THEY THE VICTIMS OF THEIR PARENTS' RAGE? OF SOCIAL WORKERS SNARLED IN REDTAPE? OR OF A SOCIETY THAT DOESN'T CARE?

(By Ruth Carlton and Kathleen O'Brien)

Two-and-a-half-year old twin girls died last year in Wayne County as a result of burns they suffered when their stepmother poured boiling water on them as they were taking their bath.

A six-month-old baby boy was found weak and close to death in a Detroit home where three other children seemed happy and well-fed.

A two-month-old baby was badly bruised when he was brought into a Detroit hospital emergency room. The mother said he had fallen out of his crib. Later, under questioning, she admitted throwing the baby across the room when he would not stop crying.

These are three of the 766 cases of child abuse reported in Michigan last year; 334 came from Wayne County. Four of the Wayne County children died—all under 27 months of age.

Most of the victims are under three . . . too young to tell what happened to them . . . too small to run away.

Doctors are required by a 1964 state law to report all suspected cases of child abuse to the Michigan Department of Social Services (MDSS). This law also protects the doctor's anonymity.

Still all authorities agree only a fraction of the abuse cases are reported.

Furthermore there is no agreement among authorities about what steps should be taken when a case of abuse is reported.

Should the abused child be removed permanently from the parents?

Should the parents be punished by having their child taken from them?

Or should an effort be made to rehabilitate the parents through social work counseling?

Should the child remain in the home while his parents go through this emotional re-education? Or should he be temporarily placed with foster parents until his own parents have learned to handle their anger and frustration a different way?

"There's a struggle in philosophy of how to handle beaten babies," says Judge James H. Lincoln of Wayne County Juvenile Court.

"The Department of Social Services seems to feel social work should be carried on without court intervention. I object; you wind up with dead kids.

"I want the Department of Social Services to offer social services; but I want them to bring each case immediately to court.

"I want an official petition filed to move the child out of the home on every abuse case."

He says parents will often agree to let children go into boarding homes without the case going to court.

"But two months later when they want the child back nothing can stop them.

"I'm in favor of social work to help the parents. But use the authority of the court to protect the child.

"Even if the court leaves the child in the home there is more control if the case has been reviewed by the court. Then the parents have to let the social worker in. It's different than social work visiting on a voluntary basis," Judge Lincoln says.

"I have a baby in the hospital now so savagely beaten he may not live," says Dr. Marilyn Heins, director of pediatrics for Detroit General Hospital.

He is an 18-month-old boy who weighed only 14 pounds when he was brought in. His tiny back is scarred from beating; his belly bloated from near starvation.

Half a dozen burn spots on his cheeks are the size of a cigarette coal.

His mother had been arrested two years ago when another of her children was brought in brutally abused.

"We (the doctor who examined him, the nurse and social worker who visited the home) all said this is a terrible situation; the children should be removed at once. But nothing happened.

"How many children from that home must suffer before someone takes action to protect the children?" the doctor asks.

A Detroit police woman says: "It is out of our hands. All we can do is report to the Michigan Department of Social Services." (Before the 1964 law, child abuse was reported to the police.)

The implication is: they report to the MDSS and nothing happens.

A social worker says, "One abused child, returned home for lack of proof that his parents were responsible, was dead two months late, as a result of 'an accident'."

Another social worker who formerly worked for the Wayne County DSS says: "There is so much paper work involved with taking a child from his home and placing him in a foster home that the social worker can't possibly offer real service to the parents or the child."

Many cases of child abuse still go unreported, says Dr. Margaret Zoliker, director of maternal, child and school health for the City-County Health Departments.

"Most doctors in private practice are gun-shy; they won't turn in a case of abuse for fear of being sued." (Even though the law protects their anonymity, a family that takes a child to their family doctor can figure out where the report came from.)

Often the doctor simply cannot believe a patient he knows is capable of beating a child, she says.

"These parents fall into two groups," Judge Lincoln says. "Those who know they are doing wrong to break a child's bones and those who think they are following the Bible on spare the rod and spoil the child."

The greatest need in Wayne County is for adequate marriage counseling, family social work, which could shore up these families, Judge Lincoln says.

"With help for the parents many of the 3,000 kids now wards of my court might be in their own homes. We would not need the constant search for boarding homes and adoptive homes if we prevented the breakdown of the family—the child's own family."

"Child abuse is just one facet of the larger problem—unwanted children," says Dr. Marilyn Heins.

"We should attack it by all methods to prevent unwanted children . . . birth control, legal abortion and subsidized adoption. Anything rather than unwanted kids."

In the meantime Dr. Heins feels the emphasis should be on protecting the child . . . especially the very young child who has no defense.

Dr. Heins says 17 percent of the children coming into Detroit General are there because of neglect or abuse.

In a study of 47 families brought before Wayne County Juvenile Court for child abuse, these facts stand out:

Twenty-six of the 47 abusive parents were under 25 years of age.

Twenty-one of the parents had married before the age of 20.

Half of the parents had failed to graduate from high school.

Many of them were mentally retarded.

Thirty-three of the 47 children abused were under three years old.

In 23 of the families the abuse was confined to one child.

The majority of the families were from the inner city.

But Dr. Zoliker stresses that the problem is not confined to the inner city.

"Although pressures are greater on poverty families who live in the inner city, abuse cuts across all boundaries. It is not limited to any economic group, nationality, race or neighborhood," she says.

Police records show many forms and types of abuse. Children have been beaten with bare fists and baseball bats. They have been burned with open flames, lighted cigarettes, electric irons and boiling water.

They have been strangled or suffocated by pillows or plastic bags. And they have been stabbed, bitten, shot, subjected to electric shock and had pepper forced down their throats.

How does abuse start?

A psychiatrist at Wayne County Juvenile Court says abuse frequently begins when a child cries and the parent cannot quiet him, or when the parent begins to toilet train the child and finds it more difficult than he had expected.

In both cases patience runs out and the parent loses control, according to the doctor.

Children who were unwanted pregnancies or children who have health problems are especially likely to be abused, he says.

"After you have seen some of these children you expect to find a huge brute of a parent who inflicted the abuse. This is not the case. The parents are usually pathetic people who you think could hardly lift a beer bottle.

"Usually only one parent is the abuser, and it's as often the mother as the father," this doctor says.

Does the parent restrict his abuse to one child?

"We used to think so. But I find when the court moves the abused child to a foster home, the parents single out another child as their victim," says the psychiatrist.

"In checking into the family's history we often find another child in the family died mysteriously."

Doctors are not sure how abused children will grow up. Whether they can ever function as citizens after the terror they have experienced. They do know that quite often the abusive parent was himself an abused child.

Will the baby lying in the hospital with the angry whip marks on his back grow up to abuse his children?

Punishing the parent is not the answer. But what is?

Dr. Heins believes one step might be the formation of an agency that would be able to handle the entire problem of abuse in one facility.

"It is quite difficult to get treatment for parents who abuse their children," says Dr. Heins. "These parents need treatment before the child is returned to the home or we are going to wind up with more dead children."

Ideally such an agency would handle only the problem of child abuse instead of the multitude of problems the Department of Social Services handles.

"No child protective work is really being done when everything is closed Saturdays and Sundays," says Rosemary Klug, chief of women's division, Detroit Police Department.

"On weekends we (the police) are the only protection agency," she says.

"Before the law was changed in 1964, child abuse was reported to the police department and investigated by policewomen. Now investigation is left to the agency (Department of Social Services) and reporting is required of doctors. They are not reporting.

"We get very few abuse cases now," Miss Klug said. "On one case last week we arrested a mother and placed the child in custody. We felt the child's life was in danger. But we will probably be criticized by Department of Social Services."

Some of the tiny cries for help from the children are being heard by the authorities.

The important job now is answering these cries before they are silenced forever.

ABUSED CHILDREN TAKE A BEATING: CHILDREN GET HURT WHILE SOCIAL WORKERS FIGHT LEGAL FORMS, REDTAPE

Detroit is failing its abused children. They get lost in a mountain of paper work which buries all efforts of the social workers hired to help them.

The social workers really care about what happens to kids or they wouldn't be there, but they can't cut through the red tape.

While I was supervisor of the Wayne County Department of Social Services abuse department, I took on an abuse case myself just to see what was involved. I thought maybe my staff was not coping efficiently. They were—as efficiently as possible under the circumstances.

On my one case I had to fill out some 30 forms—all of them long. I found myself doing hours and hours of paper work, but not doing a good job where the child and his parents were concerned.

And this was ONE case. My four social workers had an average case load of 35 families with some 130 children.

The paper road-block started 15 or 20 years ago with some simple documents. When a hole was discovered in one, a new document was written to plug the hole. But no form was ever discarded. Health, Education and Welfare came along and wanted certain information which added more forms—all of them long.

If you care what happens to children and their families, it haunts you. I finally quit. Before leaving I had asked for a revision, cutting paper work, hiring of clerical help to do essential paper work to free social workers to give service.

I still believe it can be accomplished if the public knows the conditions.

The philosophy behind the Department of Social Services approach is sound. Basically it's to try to save the family—to help the parents change so the child can remain with them.

These are the only parents the child has.

There is in most of these parents a love-hate relationship toward this child. They do love him. The parents have a great need for maturity, to solve some of their own problems.

We know when we take a child out of his home he does miss his parents even though he's been abused.

But the safety of the child is the first consideration. If he seems to be in danger, he is moved promptly to a carefully selected foster home.

Hopefully this foster home will nourish him for the year or more until he can return to his own home. The social worker will work regularly with the parents to help them mature enough to find different ways to reacting to this child. (Abusing parents are usually immature and reacting childishly to their child.)

The philosophy assumes it will take at least a year for the parents to change. And the social worker would need to see them at least once a week to bring about such a change.

In the meantime the social worker is also helping the child adjust to his foster home, arranging for visits with his own parents and after the visit help the child understand his conflicting emotions.

At the end of this ideal year the child is reconciled with his parents and moved back home.

That's the philosophy.

Would you like to hear how it works?

In reality if the social worker visits the parents briefly once in three months she's doing well.

As for that carefully selected foster home—if there is a bed empty in any licensed foster home, the child is put in that bed.

Because the child is thrown into the first foster home available, he may be thrown out of it in a couple of weeks.

These children are usually damaged emotionally by the time they are two years old. They are difficult children to handle. They may be bed wetters, fighters, sulky, withdrawn, unreasonable in their demands for attention.

So they are moved from foster home to foster home to foster home, deteriorating on the way.

And if a child is returned to his own home at the end of the year, the family probably is no different than at the time the child was removed. Nor is the child.

Before quitting my job as a social worker for abuse cases, I also pleaded that some one set up priorities.

You have the hospital demanding that an abandoned baby be removed immediately.

You have Healey Home (a temporary shelter for Juvenile Court) demanding that a child be moved into a foster home, immediately.

You have to calm down a foster mother whose payments haven't arrived for six weeks.

You have another foster mother demanding you remove a five-year-old who wets the bed and beats the other kids.

What do you do first? Some priorities must be established.

Every night I went home haunted by the things not done. Praying that the next day's papers wouldn't have a tragedy headline. For when you are dealing with abused children the thing you don't have time to do may mean a child will die . . . a parent commit suicide.

So eventually you give up the battle.

BATTERED BABY RESCUED BY SOCIAL WORKER: A 53-HOUR DRAMA

(By Ruth Carlton)

Here are the steps one social worker had to take to remove one obviously abused child from the parent's home. We will call her Miss Smith. She works for Wayne County Department of Social Services (DSS).

MONDAY

2:10 p.m. Doctor calls Wayne County Department of Social Services. He has just placed a 10-month-old boy in a private hospital whom he believes to be victim of parental abuse.

2:15 p.m. Miss Smith calls him back for his report. Baby has broken arm, black eye, burns on buttocks and possible internal injuries.

3 p.m. Miss Smith goes to hospital to see child; by coincidence meets parents there. Nurse finds private cubicle for them to talk. The parents deny everything. Miss Smith takes their address, tells them she will call on them later this afternoon.

4:20 p.m. To doctor's office, sees correspondence with California doctor who had treated this child before family moved to Michigan. California doctor had suspected parental abuse.

5 p.m. Social worker drives to child's parents' home. They had not told her it was an apartment building. No list of tenants is posted, the caretaker not at home. Miss Smith calls it a day.

TUESDAY

9 a.m. Phones caretaker and gets apartment number and telephone number for the parents.

9:30 a.m. Phones parents, explains why she had not kept her appointment the day before, outlines next steps: File a petition with the court (Wayne County Juvenile Court), judge to decide whether child returns to them. Preliminary hearing at Juvenile Court likely within three days. Angry father says he is going to hospital and get his child.

9:45 a.m. Miss Smith calls hospital, asks them to discourage parents about moving child. She assures hospital she is requesting an order of detention from court which she will deliver to hospital later today. Hospital promises nothing. Doesn't want to get involved.

10:15 a.m. She calls court to ask if detaining order can be given by phone. The answer is no. Nothing can be done without first having her written petition for the court to review the case.

10:30 a.m. Social worker types a two-page, single-spaced petition (in quadruplicate).

1 p.m. Delivers petition to court, waits for court order of detention to be typed and signed by judge.

2:45 p.m. Takes detention order to hospital. The father had left an hour earlier with the little boy.

4 p.m. Miss Smith calls the prosecutor. He advises her to request writ of apprehension the next morning.

5 p.m. Calls her supervisor and court to report.

WEDNESDAY

9 a.m. Applies for writ at Juvenile Court.

1 p.m. Phones California doctor who agrees to airmail his record of his case and x-rays. These will be vital for the court hearing.

4 p.m. Notified writ is ready. (Here comes a musical comedy situation of who is to serve writ on the parents. Wayne County Juvenile Court, seething under repeated refusals by the state legislature for adequate financial help, refuses to send an officer of the court to get the child. That, in the court's opinion, is the state's responsibility.

Miss Smith who weighs 105 pounds seems an unlikely person to take a child away from two belligerent parents. Eventually able-bodied man from another office is asked to accompany her.)

4:30 p.m. Calls police in family's precinct requesting an escort.

5 p.m. Picks up writ of apprehension at Juvenile Court, drives by police station to pick up escort.

6 p.m. Arrives at parents' home. As writ is handed to the father, another picks up the baby and walks into the bedroom. The father follows, closing the door.

6:20 p.m. Father reenters room and announces, "You can take me to jail but you can't take my baby out of here." He returns to bedroom. This scene is repeated several times until the father is persuaded to call his attorney. Attorney advises him to obey court order.

7:15 p.m. The father agrees to allow the child to be taken into care but says he and his wife will go too.

7:40 p.m. They start out . . . the social worker, the man who served the writ, the mother and her two other children in the social worker's car. The baby in the mother's arms. The baby's father drives alone followed by police car.

8 p.m. The child is placed in Detroit General Hospital—53 hours and 30 minutes after the abuse was first reported.

THURSDAY

9 a.m. Miss Smith dictates a series of reports on this case to go to the Michigan Department of Social Services in Lansing with carbons to prosecuting attorney and Juvenile Court. Various forms required for this one case fill her day.

11 a.m. She calls home-finder of Department of Social Services to ask for a foster home for the child. Fills out series of papers that set up payment to foster mother. Makes out clothing order. (When parents refuse to bring clothes to the child, new clothes must be bought.)

3 p.m. Calls hospital to arrange to pick up child and take him to foster home. But the doctor wants more tests so the baby is to be kept in hospital a few more days.

Monday the social worker will have to appear at the preliminary hearing at Juvenile Court. She is the petitioner asking the court to look into the case.

When the baby is placed in foster home, it will be Miss Smith's job to take him back to the hospital for medical followup.

She will also offer social work counseling to the parents. The first appointment will be in her office. If she thinks it safe, she will go to their home for subsequent appointments.

(This social worker is responsible for 33 child abuse cases at this time.)

MDSS goal is to close each case in 30 days referring the family to some other agency (Lafayette Clinic, Family Service, Child Study Clinic).

If the court decides not to return the child to his parents immediately, the child is made a temporary ward of the court and assigned to one of Detroit's child care agencies which will supervise him in a boarding home. All of this is accomplished with due amount of paper work.

With the total tonnage of paper involved in one case of child abuse, it is not hard to understand how the children "get lost" says one experienced social worker.

ABUSED CHILDREN: THEIR PARENTS WERE ABUSED KIDS

(By Ruth Carlton)

"Those people! I could kill them myself.

"When I think of anyone beating a small child until they break his bones . . ."

This explosion, from a gracious, poised, normally compassionate women is reflected by most of us.

The subject of battered babies strikes raw nerves and we react in anger.

"But these parents need sympathy as well as the child," plead the social workers.

"We must see abusive parents as troubled people, as greatly in need of help as is the child they have abused," says Robert Daniels, social work supervisor for Catholic Social Services of Wayne County.

"These parents are like children themselves, hostile because their own needs have been unmet and resentful because of the demands made on them as parents."

They themselves grew up in troubled families. "In fact if one point stands out, it is that problem-families beget problem-families," he says. "Somewhere we must break the cycle."

He and John A. Brown, district supervisor for Catholic Social Services of Wayne County, have followed three sets of parents since 1965 when they were referred to the agency for child abuse. Incidentally, none of these families was on public assistance.

In each case the small victim was moved immediately. With the child safe in a temporary foster home, intensive social work counseling was done with the parents.

Neither of these social workers talks in terms of success. But they are convinced these parents profited by social work.

"Now they are better able to fulfill their roles as mothers and fathers, as wage earners, than they were," says Mr. Daniels.

"We have no illusion of having solved all their problems. But because of social work they are able to function much more effectively," Mr. Brown says.

The social worker has to set modest goals in dealing with abuse cases, they say. Only one of these three battered babies has been returned to his parents. The other two have been placed in adoptive homes.

Here are the three cases:

CASE NO. 1

Danny Stevens, 14 months old, was removed from his home because of repeated abuse by his mother.

Mrs. Stevens was retarded and emotionally disturbed. She had had a troubled childhood centered around an alcoholic father and a disturbed, rejecting mother.

Her relationship to her mother had been hostile but dependent and the mother had exerted constant control over her life.

Danny had been born just a week after Mrs. Stevens' mother died. These two events were so closely associated in Mrs. Stevens' mind that she rejected her son from birth, could not bear to hold him. She reacted with rage if the baby cried to be fed or diapered.

After the court took Danny out of this home, Mrs. Stevens talked every week with the social worker. She made enough progress that Danny was returned home after 14 months. There has been no further abuse; Mr. Stevens continues to see the social worker once a month now.

CASE NO. 2

Mr. Carson was brought to court for abusing his infant son. He told the judge he had been angry when his wife left him babysitting. The baby cried, and because he could not stop the crying, he picked up the child and flung him across the room.

Mr. Carson was a depressed dependent person. He was still mourning for his father who had died four years before. His mother had recently married a man of whom Mr. Carson disapproved.

Some way Mr. Carson associated the helplessness of his son with his own helplessness which was compounded now by feeling deserted—deserted by his father's death, deserted by his mother's remarriage, deserted by his wife's leaving their baby with him.

The baby was moved to a foster home. Social work counseling began for Mr. Carson. Both parents are what the social workers call "limited" . . . more popularly called retarded. The man was willing to give up the child, his wife was not. So the court took permanent court custody of the little boy.

Today Mr. Carson is in the process of getting a divorce.

Mrs. Carson and her daughter have gone to live with her mother.

An adoptive home is lined up for the son who is now four years old. The little boy has some brain damage from the abuse. But the adoptive parents want him even though the doctors do not know how severe the brain damage is.

CASE NO. 3

The Jones family came to the attention of the Juvenile Court when Mrs. Jones demanded they take her three-year-old son George. She threatened to kill him if they didn't.

Mrs. Jones also had three little girls. She was an inadequate mother, but this did not include abusing them. She could not tolerate her son George. She beat him severely and put him outside in near zero weather to punish him.

She resented the attention paid George by his father and other adults.

Mrs. Jones was retarded, came from a home where she was neglected, and had been placed in a state training school for delinquents in her early teens.

Mrs. Jones gave up her boy to be adopted. He is now thriving in an adopted home and the Jones family is still intact—mother, father and three daughters.

"These three parents who abused their children all came from problem families," says Mr. Daniels.

"In trying to help them we focused on the parents themselves and not on the act of abuse. We tried to convey to them our concern over their situation and to provide a climate of goodwill in which we could work with them."

Occasionally the social worker made suggestions about child care and the rearrangement of routines.

A housekeeper to be with a mother who had abused her child during the day while the father was at work.

Day care for a two-year-old so the mother could get some relief.

Mr. Daniels sees abuse as a result of a variety of forces operating on the parents: Their psychological needs, limited intellect, social pressures and economic adversities.

"Where there is a problem of child abuse, there are invariably other problems in the family," he says.

Mr. Daniels sees abuse "not as an intentional act of violence on a child or as merely the result of parental rage, but rather as a response to the parent's overwhelming anxieties and to the hostility engendered by them, which somehow the child seems to intensify."

He feels that social work might be more effective if the neighbors and relatives of abusive parents could stop looking upon them as criminals and see them as deeply troubled human beings.

Perhaps then the cycle could be broken . . . that destructive cycle of abused children become abusing parents.

BATTERED BABIES: LOTS OF ORGANIZATIONS BUT TRAGICALLY LITTLE SERVICE

(By Ruth Carlton)

Michigan's failure to protect battered babies and rehabilitate their parents is part of the reason State Department of Social Services is now under fire.

A bill has been introduced to remove child neglect (which includes abuse) from the State Department of Social Services (SDSS).

Senate Bill No. 196, introduced Feb. 26 by Senator Lorraine Beebe, of Dearborn, would set up a new state department—Department of Youth Services—taking both child neglect and delinquency away from the State Department of Social Services.

Judge James H. Lincoln, of Wayne County Juvenile Court, who is one of the supporters of the bill, says: "I do not want to attack personalities. I'm really not interested in who is to blame. But some children's services have to be shifted from SDSS.

"There is no question that the Romney Commission (the Governor's Commission on Youth Problems) report is a hell of an indictment of lack of leadership." (The bill resulted from this report.)

Judge Lincoln referred to his recent request addressed to Bernard Houston, SDSS director, dated April 24:

"I wish to again reiterate the urgent need for five or more additional workers in Wayne County, to be assigned specifically to child abuse cases.

"The Department's (SDSS) policy of dropping cases after 30 days is just simply nonsense. The Department of Social Services is handling the entire neglect load of a number of counties. In Wayne County, their services are either paper thin or nonexistent.

"If the Department of Social Services were to give the same services to Wayne County that now are being furnished to some other counties, it would take no less than 30 workers," the letter said.

Houston's reply to the judge stated he was referring the request to the appropriations committee. "Which means he isn't going to do anything," the judge commented.

"Houston is in an extremely difficult position," the judge continued. "His requests for money from the state legislature are ignored unless some outside group comes up screaming.

"But to get money for a project you have to plan, document, present a five-year plan, and promote it. This SDSS has not done.

"If anything there has been a decrease in services in Wayne County since the merger (the 1965 merger of state, county and city welfare services under SDSS)."

From court to hospital to social workers there is agreement that the battered baby problem can be solved only with adequate casework for the parents. Helping unstable, frustrated, immature parents is also the best prevention known for battered babies.

Increasingly it is suggested the State of Michigan should set up these services rather than depending on the efforts of Catholic Social Services and Children's Aid Society, both private Torch Drive supported agencies.

"The battered baby is only one part of a broader problem of grossly inadequate care and protection of children in many kinds of situations," says Eben W. Martin, family and child welfare consultant of United Community Services and president of the Detroit chapter of National Association of Social Workers.

"A comprehensive, early, child protective and family strengthening service is greatly needed in Michigan. This kind of program is provided in many states by a public agency," Mr. Martin said.

What are protective services?

"Catching a family in trouble before tragedy overtakes them . . . working with them before they harm or kill a child," is one social worker's definition.

Actually Detroit has several fragmented, isolated attempts along this line. Five workers here, six workers there, against unknown thousands of families needing such services.

Here is what Detroit offers these families:

Wayne County Department of Social Services: Five abuse workers who, by plan, would work with the parents for 30 days. (The court calls the 30-day limit "simply nonsense." The social workers say they have no time left for social work if they complete the paper work.)

Wayne County Juvenile Court's Child Study Clinic: No long term service offered. Parents are interviewed before the court hearing decides whether or not to return their child.

Children's Aid Society: The Torch Drive agency responsible for protective services to Protestant families. The department has decreased from nine workers to five in the last five years.

Catholic Social Services: Provides casework service "that contributes toward a stable and healthy family life" to Catholic families.

Protective Service Unit: Five workers. Set up two and a half years ago with services provided by Catholic Social Services, money by SDSS. Available to any family regardless of religion.

Families are referred by police or schools when children are so blatantly neglected that there is danger to the child.

"We go to their home saying, 'We hear you are having difficulty and we will try to help,'" says Virginia LaFaice, director of the unit.

She plans to introduce a new approach later this month: Group counseling for six to eight mothers.

The First Unitarian Church, 4605 Cass, has agreed to house the project, rent free. Miss LaFaice is looking for volunteer drivers who will pick up the mothers and their children.

She also needs volunteers experienced in nursery school techniques so the session will be a growing experience for children as well as mothers.

SDSS specifies that services be limited to 90 days.

Can parents be changed in 90 days?

"We try to find the family's most immediate problem related to the child and concentrate on that. In 90 days we know how it's going—whether the family is catching a gleam of hope or whether to refer the case to Juvenile Court," Miss LaFaice says.

"Sometimes in 90 days a parent decides he can't handle it. A man whose wife has died leaving him with young children may ask that they be placed in a foster home temporarily.

"Often we refer the family after our 90 days to other UCS agencies," she says.

Obviously the total combined services offered by these small projects can touch only an infinitesimal fraction of parents of neglected and abused children.

There's no way of knowing their total number but at least three thousand of their children are now wards of the Wayne County Juvenile Court.

The conviction that it is preferable to strengthen the existing family and hopefully return the abused child to it is based on:

The damage to the child when he is uprooted.

The difficulty in finding enough foster homes.

The danger that when a shortage of foster homes exists a child may be put into a home no better than the one he's leaving.

In fact Dr. Paul V. Woolley Jr., pedia[illegible]an-in-chief of Children's Hospital of [illegible]igan, reports three cases of battered babies abused by foster parents.

Dr. Woolley was one of the pioneers in recognizing the battered baby syndrome. When he first published in medical journals a dozen years ago, many doctors were explaining the multiple fractures in infants as some mysterious ailment of bone fragility.

Dr. Woolley has just completed a chapt[illegible] on battered babies for a new medical t[illegible] in which he gives data on 55 construc[illegible] cases of physical abuse admitted to Children's Hospital.

Age	Number
Under 3 months	12
3 to 6 months	13
6 to 12 months	14
12 to 24 months	7
24 to 36 months	5
Over 36 months	4

Six of the babies died. Four are known to have permanent damage.

In writing of possible solutions, Dr. Woolley says:

"Sometimes material assistance and moral support for those (parents) where frustration and immaturity are evident suffices.

"In others a close and constant tie to a person skilled in interhuman relations has helped. Some benefit from psychiatric approaches. . . ."

As a last resort he lists "long-term removal of the victim through court action."

"Even this is not a cure-all," he writes, adding that three of his 55 cases were battered in foster homes after having been removed from their parents because of abuse or neglect.

"It is self-evident that no amount of legislation can help unless supported by an enlightened concern on the part of the community, the courts and the medical profession," he says.

BATTERED BABIES: VICTIMS OF THEIR PARENTS OR OF SOCIETY?

(By Ruth Carlton)

In this series on battered babies charges have been made against the State Department of Social Services (SDSS) headed by Bernard Houston.

A former head of the abuse department for one county Department of Social Services says she resigned because a ridiculous amount of required paper work prevented her from giving social work services.

Both court and police implied criticism of the handling of abuse cases by the Department of Social Services.

The social worker said she filled out as many as 30 forms on one case.

"Nowhere can we find where as many as 30 forms could possibly have been required," Mr. Houston says in a written statement. "We do have a forms problem but it is not within the battered child program itself.

"Only five forms are actually required for the department workers to carry out the responsibility vested in us through Act 98, which is to:

(1) Determine if intentional injury occurred.

(2) Refer to proper law enforcement.

(3) Maintain information registry."

However, Mr. Houston then goes on to list circumstances in which "other forms will be necessary" if additional services are required through another agency "whether these are court forms or the forms of another program in this department."

Also two forms orginate with the county board of auditors. And extra forms are necessary for Medicaid, he notes.

The News learned from another social worker that 30 forms is a conservative estimate in abuse cases. One must be filled out on every child in the family, not just on the one abused child.

Four children in the family means the same form must be filled out four times.

And this series of four must be repeated each time the abused child moves—say from hospital to foster home, on to a second foster home.

Mr. Houston says some forms had been discontinued before The Detroit News article, and three others have been combined since.

He says the required forms have not blocked the efficiency of his staff in Wayne County citing that out of 306 referrals in 1968, 177 were confirmed as abuse.

Sixteen children were removed permanently from their parents and 66 temporarily.

Answering the criticism of local police and court, as reported in Sunday's News, Mr. Houston wrote:

"To our knowledge there simply is no conflict of philosophy between SDSS and the juvenile court. Neither responsibility nor authority is removed from the hands of police and the court."

To indicate cooperation with the court, Mr. Houston points out 31 of the first 84 abuse cases in April were filed with Wayne County Juvenile Court.

State Department of Social Services has established protective services in 16 counties. Wayne County is not one of them.

Mr. Houston claims, "Extremely high priority has been given the battered child program in Wayne County. In January instructions went to staff to cut caseloads which had been 60 down to 30."

The abused child program was separated from neglect to form a seperate unit, and the most qualified staff assigned to it, he says. Also one staff member was assigned as liaison to each large hospital.

Mr. Houston says, "A series of statewide workshops on battered children are being set up with Probate Judges Association, the Supreme Court, the Prosecutors' Association and the Attorney General's office."

He points out that while a 1965 law gave SDSS broad responsibility to investigate battered baby charges and provide services, sufficient money has never been allotted to carry out this responsibility.

Critics of SDSS agree the state legislature has never come through with the necessary money. But some believe this is as much due to lack of leadership and promoting on the part of SDSS as to any niggardly attitude of the legislators.

What does this all add up to?

Obviously Michigan babies are still being battered around.

Obviously not enough counseling is available to their parents.

Obviously a preventive approach is needed to keep more babies from being abused.

What is the answer?

Transfer of responsibility to a separate State Department of Youth as proposed in Senate Bill 198?

Preventing unwanted children by more emphasis on planned parenthood and abortion as suggested by Dr. Marilyn Heins, director of pediatrics at Detroit General Hospital?

More funds from the state legislature so State Department of Social Services can do a better job?

Aroused citizens who will demand attention for those too little to run their own protest movement?

As one social worker put it, "It boils down to too little money, too few workers, too few facilities. Only by getting citizens aroused can you ever change the establishment."

D. Appendix IV

New York Times Article, Congressional Record, May 27, 1969

RISE IN CHILD ABUSE

HON. MARTHA W. GRIFFITHS

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Tuesday, May 27, 1969

Mrs. GRIFFITHS. Mr. Speaker, last week I placed a series of articles from the Detroit News on the subject of Michigan's battered babies in the CONGRESSIONAL RECORD. These articles pointed to the emotional and physical horrors of child abuse where in Michigan alone last year the reported number of cases totaled [illegible].

However, child abuse is not only a problem in the State of Michigan but in our entire Nation. Recently, the New York State Department of Social Welfare announced that in 1968 there was a 30-percent increase in the number of reported cases of child abuse. This was discussed in a recent New York Times article entitled "Rise in Child Abuse," written by Howard A. Rusk, M.D. This article stated that in the last several weeks five children have been killed at the hands of their parents and that of the 987 cases reported in New York City last year 36 were fatal. Certainly, I cannot stress too much the importance of curtailing child abuse and that I feel every citizen has a responsibility to report any suspected case of mistreatment of children. This problem can be found today among people of every educational, religious, socioeconomic, and geographical background in America.

At this point, I place the text of the article in the CONGRESSIONAL RECORD for everyone to read:

RISE IN CHILD ABUSE: PROBLEM REQUIRES MORE TRAINED HELP, MORE FUNDS AND THE COOPERATION OF ALL

(By Howard A. Rusk, M.D.)

Last week the New York State Department of Social Welfare announced that in 1968 there was a 30 per cent increase in the number of reported cases of child abuse.

Certainly the problem of child abuse in New York City has been highlighted by the fact that in the last several weeks five children have been killed at the hands of their own parents.

New York City is not alone in this problem. Similar increases are being reported throughout the country.

There is also no doubt that there is increased professional concern with the problem and less tolerance of the "rights of parents" for those who practice child abuse.

Ironically the law for the protection of animals was enacted before child protection statutes. In fact the successful use of animal protection statutes in behalf of a cruelly abused little girl in 1874 provided the impetus for the founding of the New York Society for the Prevention of Cruelty to Children in 1875.

BATTERED CHILD SYNDROME

Professional concern among physicians came from the first study of the problem in 1961 by Dr. Henry Kempe at the University of Colorado Medical Center.

It was from this study that the terrifying and ugly new medical phrase was developed—the battered child syndrome.

In this study, 71 hospitals reported treatment of 302 such cases in a year. Of the group, 33 had been abused so severely they died and 85 others suffered permanent brain damage.

Of the 987 reported cases in New York City last year 36 were fatal.

Before Dr. Kempe's study, California was the only state in which parental abuse of the child was a criminal offense. All states now have such laws. The New York City law was recently amended to attempt to improve reporting.

Effective June 1, hospital personnel, social workers and school officials will be added to the list of those engaged in the healing arts required by law to report cases of child abuse.

The state law required that such cases be reported orally as soon as practicable and that a written report be submitted to local social service officials within 48 hours. Presently the major source of reports is from hospitals.

Unfortunately there was a sharp decline last year of 60 per cent in the number of suspected child abuse cases reported by physicians. The number of cases reported by physicians dropped from 15 per cent in 1967 to 9 per cent in 1968.

One of the reasons for the decrease may be that some physicians hesitate to report such cases because of their belief that the right of privileged communication is violated. However, persons and institutions required by law to make such reports are provided immunity from civil and criminal suits brought about as the result of their reports.

AVOIDING INVOLVEMENT

In many instances physicians and other health and social welfare workers simply do not want to get involved in a messy situation.

Commissioner George K. Wyman, New York State Department of [illegible] Welfare, pointed out in last [illegible] announcement that "Disturbing as this figure is, it tells us an incomplete story because there are many other such cases of child-battering—hundreds more—that are not reported by persons aware of them."

He stressed that under-reporting is a serious situation especially if the dead or abused child has brothers or sisters living at home but not protected.

This is underlined by the fact that 14 per cent of the children reported last year in suspected abuse cases were siblings. These 185 children were from 56 families in which two or more children were suspected of being abused.

What such an environment of terror means and does to a child is too horrible even to contemplate.

Studies have shown that parents are the offenders in most instances of child abuse. There are some cases, however, of other persons such as baby-sitters, paramours and siblings as the offenders.

Last week this writer discussed the problem with Dr. Vincent J. Fontana, who has long been interested in the problem. Dr. Fontana is director of pediatrics, St. Vincent's Hospital and Medical Center, and medical director of the New York Foundling Hospital. He said:

"The child abuse law that we now have in all states in the United States in itself is just the first step that can be taken to protect the abused or neglected child.

"What is more important is what happens after the report.

LACK OF COMMUNICATION

"At the present time, from our experience we have found there has been little or no communication between various disciplines that are responsible for protecting the child and assisting the parents. This applies to the physician who does the reporting, the child protective unit that does the investigating, and the judge who makes the determination as to whether the child is to be returned home or goes to an institution or foster home.

"Unless there is mutual cooperation and communication with follow-up under these various disciplines, the job of protecting the child and helping to assist the parents will not be realized.

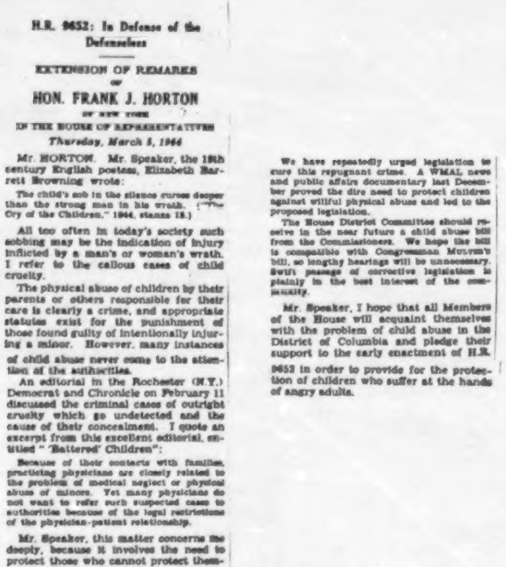
"In attempting to solve these tragic problems it is hoped that there will arise a mutual respect between the physician, social worker and judge so that a proper decision may be reached to protect the child from further abuse and possible death."

In reality, Dr. Fontana's hope can only be accomplished if there are adequately trained people in the child protective unit, sufficient funds to employ a large enough staff to handle the large number of abused and neglected child problems and an adequate number of judges in the family courts.

The blame is not on any individual but an overwhelming caseload and an inadequate staff.

The reporting of suspected cases of child abuse should not be limited to professional workers in the field of health and welfare. Every citizen has a responsibility to report any suspected case of child abuse.

Statement of the Hon. Frank J. Horton, Congressional Record, March 5, 1964:



H.R. 9652: In Defense of the Defenseless

EXTENSION OF REMARKS
OF
HON. FRANK J. HORTON
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Thursday, March 5, 1964

Mr. HORTON. Mr. Speaker, the 19th century English poetess, Elizabeth Barrett Browning wrote:

> The child's sob in the silence curses deeper than the strong man in his wrath. ("The Cry of the Children," 1844, stanza 13.)

All too often in today's society such sobbing may be the indication of injury inflicted by a man's or woman's wrath. I refer to the callous cases of child cruelty.

The physical abuse of children by their parents or others responsible for their care is clearly a crime, and appropriate statutes exist for the punishment of those found guilty of intentionally injuring a minor. However, many instances of child abuse never come to the attention of the authorities.

An editorial in the Rochester (N.Y.) Democrat and Chronicle on February 11 discussed the criminal cases of outright cruelty which go undetected and the cause of their concealment. I quote an excerpt from this excellent editorial, entitled " 'Battered' Children":

> Because of their contacts with families, practicing physicians are closely related to the problem of medical neglect or physical abuse of minors. Yet many physicians do not want to refer such suspected cases to authorities because of the legal restrictions of the physician-patient relationship.

Mr. Speaker, this matter concerns me deeply, because it involves the need to protect those who cannot protect themselves. Further, it is a matter that concerns Congress, since child abuse legislation affecting the District of Columbia is presently pending in the House.

The gentleman from New York [Mr. MULTER] has introduced H.R. 9652, a bill to provide for the mandatory reporting by physicians and institutions in the District of Columbia of certain physical abuse of children. I solidly support this legislative proposal.

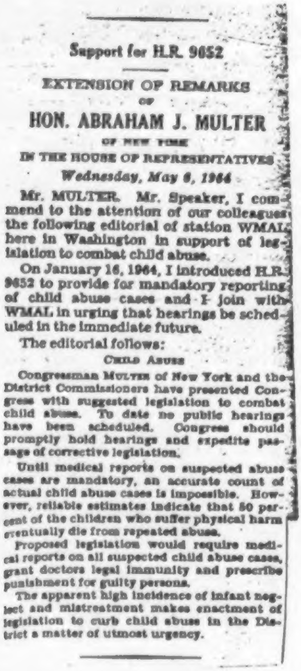
I have the pleasure to serve as a member of Subcommittee No. 3 of the Committee on the District of Columbia, which the gentleman chairs. I know firsthand his dedicated desire to see this Congress enact legislation which would require doctors or hospitals to report suspected child abuse cases to the police. The bill would require such reporting and would guarantee immunity from legal suits for those making the reports.

It should be noted that this measure has gained editorial support from an important broadcasting company in Washington. In early February, WMAL, WMAL-FM, and WMAL-TV offered the following statement of opinion to their viewers and listeners:

> CHILD ABUSE
>
> The Commissioners have, quite rightly, ordered the Corporation Counsel's office to draft corrective child abuse legislation. Congressman MULTER, of New York, has already introduced a bill to provide mandatory medical reports of suspected physical abuse cases.
>
> The Multer bill would require doctors to report suspected cases to police and would grant legal immunity to doctors from any civil or criminal action that resulted from their reports.
>
> Ten States now have child abuse laws. Children of the District need similar protection.
>
> We have repeatedly urged legislation to cure this repugnant crime. A WMAL news and public affairs documentary last December proved the dire need to protect children against willful physical abuse and led to the proposed legislation.
>
> The House District Committee should receive in the near future a child abuse bill from the Commissioners. We hope the bill is compatible with Congressman MULTER's bill, so lengthy hearings will be unnecessary. Swift passage of corrective legislation is plainly in the best interest of the community.

Mr. Speaker, I hope that all Members of the House will acquaint themselves with the problem of child abuse in the District of Columbia and pledge their support to the early enactment of H.R. 9652 in order to provide for the protection of children who suffer at the hands of angry adults.

Statement of Hon. Abraham J. Multer, Congressional Record, May 7, 1964:



Support for H.R. 9652

EXTENSION OF REMARKS
OF
HON. ABRAHAM J. MULTER
OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES
Wednesday, May 6, 1964

Mr. MULTER. Mr. Speaker, I commend to the attention of our colleagues the following editorial of station WMAL here in Washington in support of legislation to combat child abuse.

On January 16, 1964, I introduced H.R. 9652 to provide for mandatory reporting of child abuse cases and I join with WMAL in urging that hearings be scheduled in the immediate future.

The editorial follows:

CHILD ABUSE

Congressman MULTER of New York and the District Commissioners have presented Congress with suggested legislation to combat child abuse. To date no public hearings have been scheduled. Congress should promptly hold hearings and expedite passage of corrective legislation.

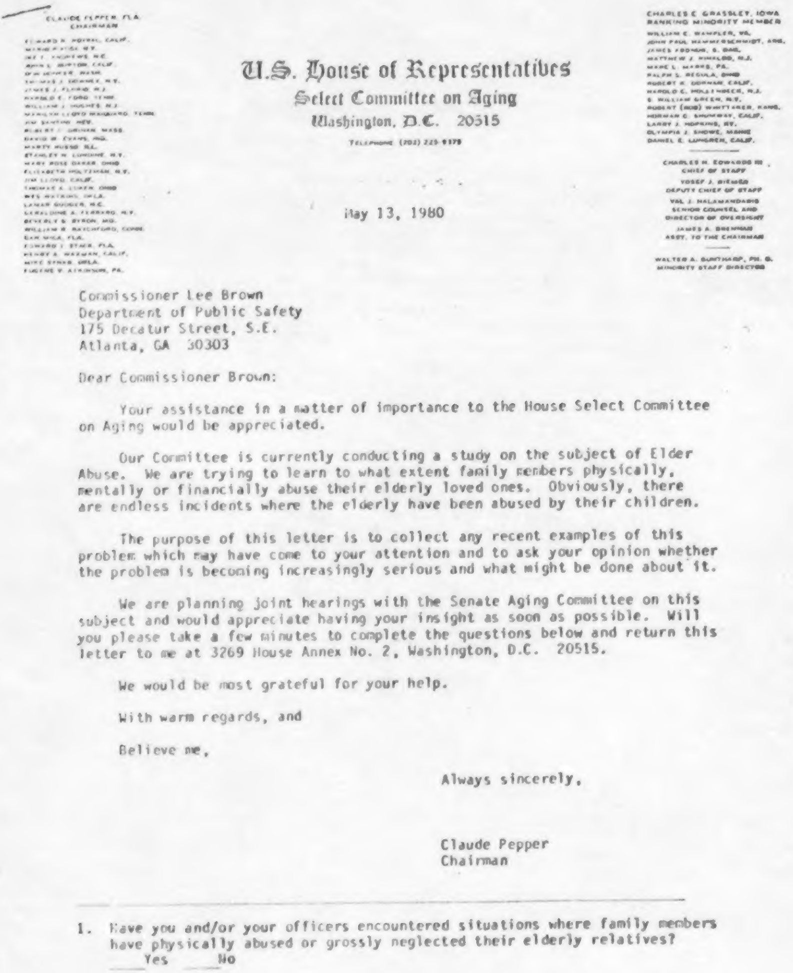
Until medical reports on suspected abuse cases are mandatory, an accurate count of actual child abuse cases is impossible. However, reliable estimates indicate that 50 percent of the children who suffer physical harm eventually die from repeated abuse.

Proposed legislation would require medical reports on all suspected child abuse cases, grant doctors legal immunity and prescribe punishment for guilty persons.

The apparent high incidence of infant neglect and mistreatment makes enactment of legislation to curb child abuse in the District a matter of utmost urgency.

APPENDIX V

Sample of Questionnaire sent to Police Chiefs in major metropolitan cities in the United States



CLAUDE PEPPER, FLA.
CHAIRMAN

U.S. House of Representatives
Select Committee on Aging
Washington, D.C. 20515

CHARLES E. GRASSLEY, IOWA
RANKING MINORITY MEMBER

CHARLES H. EDWARDS III,
CHIEF OF STAFF

VAL J. HALAMANDARIS
SENIOR COUNSEL AND
DIRECTOR OF OVERSIGHT

JAMES A. BRENNAN
ASST. TO THE CHAIRMAN

WALTER A. GUNTHARP, PH. D.
MINORITY STAFF DIRECTOR

May 13, 1980

Commissioner Lee Brown
Department of Public Safety
175 Decatur Street, S.E.
Atlanta, GA 30303

Dear Commissioner Brown:

Your assistance in a matter of importance to the House Select Committee on Aging would be appreciated.

Our Committee is currently conducting a study on the subject of Elder Abuse. We are trying to learn to what extent family members physically, mentally or financially abuse their elderly loved ones. Obviously, there are endless incidents where the elderly have been abused by their children.

The purpose of this letter is to collect any recent examples of this problem which may have come to your attention and to ask your opinion whether the problem is becoming increasingly serious and what might be done about it.

We are planning joint hearings with the Senate Aging Committee on this subject and would appreciate having your insight as soon as possible. Will you please take a few minutes to complete the questions below and return this letter to me at 3269 House Annex No. 2, Washington, D.C. 20515.

We would be most grateful for your help.

With warm regards, and

Believe me,

Always sincerely,

Claude Pepper
Chairman

---

1. Have you and/or your officers encountered situations where family members have physically abused or grossly neglected their elderly relatives?
____Yes ____No

2. In your jurisdiction, would you say this problem: ____is widespread, ____occurs often, or ____occurs rarely.

3. Would you say the incidence of this problem has increased over the last five years? ____Yes ____No

4. Can you provide our Committee with examples of this kind of physical abuse? If so, please enclose files or summaries of any case histories you may have. You need not identify the parties involved. Please delete or substitute Mr. X, Mrs. Y or Miss Z for actual names, if necessary.

5. Have you encountered situations where family members have financially abused their elderly loved ones? ____Yes ____No

6. In your jurisdiction, would you say this problem: ____is widespread, ____occurs often, or ____occurs rarely.

7. Would you say the incidence of this problem has increased over the last five years? ____Yes ____No

8. Can you provide our Committee with any examples of financial abuse of the elderly? Again, you may delete names if necessary.

9. Can you suggest anyone else the Committee should contact who is knowledgeable on this issue?

Name ______________________________

Address ______________________________

City ______________ State __________ Zip __________

10. Would you be interested in testifying before the Committee? ____Yes ____No

Name ______________________ Phone (____) ______________

11. We welcome any additional comments you may have: ______________________________

____

____

THANK YOU FOR YOUR ASSISTANCE.

APPENDIX VI

Sample of Questionnaire sent to Staff of the Visiting Nurses Association of the District of Columbia and Maryland relating to Abuse of the Elderly

CLAUDE PEPPER, FLA.
CHAIRMAN

[illegible]

CHARLES E. GRASSLEY, IOWA
RANKING MINORITY MEMBER

[illegible]

U.S. House of Representatives
Select Committee on Aging
Washington, D.C. 20515

Telephone: [illegible]

October 17, 1980

TO ALL STAFF OF THE VISITING NURSES ASSOCIATION OF THE DISTRICT OF COLUMBIA AND MARYLAND

Dear Friends:

You will be interested to learn that the House Select Committee on Aging is in the process of conducting a survey of all staff of the Visiting Nurses Association of the District of Columbia and Maryland to gain a better understanding of your activities with respect to protecting victims of domestic violence. Our specific interest is with elder abuse -- abuse of the elderly by their children, other relatives or caretakers.

There has been a great deal of publicity on this subject in recent months including joint hearings by the House and Senate Committees on Aging. The purpose of this letter and the enclosed questionnaire is to learn from your experience. We welcome any suggestions you would care to make. As you will see, we are interested in what authority you now have to intervene when incidents of elder abuse come to your attention and the number of such cases which you encounter. Most importantly, we look forward to receiving from you case histories which have come to your personal attention during your service with the Visiting Nurses Association.

We hope you will take the time to respond to this inquiry which we regard as a priority issue. We have been advised that Ms. Dorothy Nelson, Director of the Visiting Nurses Association for the District of Columbia and Maryland, and Mrs. Libby Gittenstein, Mental Health Consultant, will be assisting the Committee in this effort.

We are most grateful for your assistance in this important matter. If you have any questions please contact Ms. Kathy Gardner of the Committee staff at (202)225-8077.

With warm regards, and

Very sincerely,

Claude Pepper
CLAUDE PEPPER
Chairman, House Select Committee on Aging

Mary Rose Oakar
MARY ROSE OAKAR
Member, House Select Committee on Aging

CP:ktg

QUESTIONNAIRE TO ALL STAFF OF THE VISITING NURSES ASSOCIATION OF THE DISTRICT OF COLUMBIA AND MARYLAND RELATING TO ABUSE OF THE ELDERLY

There has been a great deal of publicity in recent months regarding the financial, psychological, and physical abuse encountered by older Americans at the hands of their loved ones -- sons, daughters, relatives and caretakers. Some States have responded to this problem by establishing special units within existing departments to respond to complaints of elder abuse. Other States have expanded the coverage of existing adult protective services to include the elderly as in need of services. The purpose of this questionnaire is to gain a better understanding of your personal experiences with respect to protecting victims of elder abuse.

BACKGROUND INFORMATION

1. Are you employed with the Visiting Nurses Assocation as a:

Visiting Nurse ____
Physical Therapist ____
Social Worker ____
Home Health Aide ____
Other (Please Explain) ____________________

2. How long have you been employed by the Visiting Nurses Association?

0 - 6 months ____
7 months - 1 year ____
1 year - 2 years ____
2 years or more ____

ABUSES

1. How many patients did you visit in 1980?__________ In 1979?__________

2. Approximately how many of these patients were over the age of 60 in 1980?__________ In 1979?__________

3. Approximately many of the patients over age 60 that you served had been abused? In 1980?__________ In 1979?__________

4. Experts have indicated that many elderly persons (over the age of 60) are abused by their children, relatives or caretakers in obvious as well as in subtle ways. The following section of this questionnaire is to ask if you have ever encountered any of the following abuses:

A. Physical Abuse - This includes deliberate acts leading to injury of the older person, such as beating, withholding medication, food and personal care necessary for their well-being. This also includes "neglect," such as the excessive use of sleeping medication or alcohol to make the older person who needs constant watching, etc. ___Yes ___No

B. Psychological Abuse - This includes verbal assault and threats, provoking fear and isolation. This type of abuse usually preceeds physical abuse. It may involve the threat of unnecessary nursing home placement or various other mistreatments. ___Yes ___No

C. Material or Financial Abuse - Includes the theft of money or personal property. The appointment of a conservator or guardian who does not handle an older person's estate in their best interest. ___Yes ___No

D. Violation of Rights - This includes being forced out of one's dwelling or being forced into another setting against the older person's will. ___Yes ___No

E. Other - Explain:____________________
____
____

5. In your estimation, of the elder abuse you encountered this year, how many involved:

Physical Abuse ____%
Psychological Abuse ____%
Financial Abuse ____%
Violation of Rights ____%
Other ____% Explain: ____________________

6. What percentage of the elder abuse cases that came to your attention were substantiated?__________% Unsubstantiated?__________% Inconclusive evidence?__________%.

7. Would you say the incidence of elder abuse is increasing?______Yes ________No.

8. What percentage of elder abuse is perpetrated by relatives?______%

In cases where family members or relatives commit such abuse, what percent of them would you guess are perpetrated by each of the following:

Husband ____%
Wife ____%
Son ____%
Daughter ____%
Daughter-in-law ____%
Son-in-law ____%
Grandson ____%
Granddaughter ____%
Other relatives (Specify) ____% ____________________

9. What percentage of elder abuse is perpetrated by caretakers unrelated to the abused? ________%

In cases where caretakers unrelated to the victim commit such abuse, what percent of them would you guess are perpetrated by each of the following:

Unrelated conservator/guardian ____%
Live-in caretaker ____%
Other (Specify) ____% ____________________

10. In your opinion, what were the underlying causes which resulted in abuse of the elderly?

Abusive behavior is a response to stress ____%
Abusive behavior is a form of revenge (abuser was abused as a child) ____%
Abusive behavior is a response to lack of community services ____%
Abusive behavior is a response to alcoholic problems ____%
Abusive behavior is a response to psychological problems ____%
Other (Specify) ____________________ ____%

INTERVENTIONS

1. How would you go about reporting abuse?____________________
____

2. When an incident of elder abuse is encountered, what types of action are most frequently utilized:

	Never	Rarely	Frequently	Always
Notification of Police	____	____	____	____
Relocation (either temporarily or permanently) of abused or abuser from place where abuse took place	____	____	____	____

	Never	Rarely	Frequently	Always
Counselling with those involved	____	____	____	____
Linking those involved with needed services such as:				
a) Medical	____	____	____	____
b) Housing	____	____	____	____
c) Financial	____	____	____	____
d) Legal	____	____	____	____
e) Other social services	____	____	____	____

Other (Specify)____

3. What is the most effective means of intervention, in your opinion?
____

4. Does your association have written instructions or procedures concerning intervention?____

5. What barriers make it difficult for your to provide assistance to victims of suspected or substantiated abuse?____________________
____

6. What must be done to make it possible for you to provide assistance to victims of suspected or substantiated abuse?____________________
____

7. To what extent is the general public aware of the problem of elder abuse and the work of the visiting nurses association in this regard?
____Very Aware ____Moderately Aware ____Unaware.

STATE AND FEDERAL REGULATION

1. Based on your experience, to what extent are the needs of the elderly met through existing state laws or regulations?

Not at all ____%
Occasionally ____%
Frequently ____%
Always ____%
Do not know ____%

2. Would you favor Federal legislation to establish model mandatory reporting requirments for elder abuse to be adopted by the States?
____Yes ____No. If yes, who should be required to report?________
____
____

3. Enclosed is a copy of our bill, H.R. 7551, "Prevention, Identification, and Treatment of Adult Abuse Act of 1980," and a statement summarizing its provisions. Would you support the passage of this measure?
____________Yes __________No ____________Undecided.

REQUEST FOR FURTHER INFORMATION

1. Will you please provide the Committee with typical case histories of elder abuse which have come to your attention? Please feel free to delete names of individuals or visiting nurse employees if you so desire.

APPENDIX VII

Directory of State Offices Responsible for Adult Protective Services:

ALABAMA
State Department of Pensions
and Security
Bureau of Adult Services
64 North Union Street
Montgomery, Alabama 36130

ALASKA
Division of Social Services
Department of Health and Social
Services, Pouch H-05
Juneau, Alaska 99811

ARIZONA
Aging and Adult Administration
1400 West Washington
Phoenix, Arizona 85007

ARKANSAS
Adult Protective Services
Donaghey Building, Rm. 1428
Little Rock, Arkansas 72201

CALIFORNIA
Department of Social Services
Adult PROTECTIVE Supportive
Services Bureau
744 P Streetm N,S. 5-141
Sacramento, California 95814

COLORADO
Colorado State Department of
Social Services
Adult Programs
1575 Sherman
Denver, Colorado 80203

CONNECTICUT
State of Connecticut
Department on Aging
90 Washington Street
Hartford, Connecticut

DELAWARE
Department of Health and
Social Services
New Castle, Delaware 19720

DISTRICT OF COLUMBIA
Protective Services for Adults
Room 613
122 C Street, N. W.
Washington, D. C. 20001

FLORIDA
Aging and Adult Services Program
Office
1317 Winewood Blvd.
Tallahassee, Florida 32301

GEORGIA
Division of Family and Children's
Services
Social Services Section
618 Ponce de Leon Avenue
Atlanta, Georgia 30308

HAWAII
Social Services Intake Unit
1149 Bethel Street, Room 400
Honolulu, Hawaii 96813

IDAHO
State of Idaho
Division of Welfare
Statehouse
Boise, Idaho 83720

ILLINOIS
State Agency on Aging
421 E. Capitol Avenue
Springfield, Ill. 62706

INDIANA
Commission on Aging and Aged
Graphic Arts Building
215 North Senate Avenue
Indianapolis, Indiana 46202

IOWA
Bureau of Adult Services
Hoover State Office Building
Des Moines, Iowa

KANSAS
Adult Services Section
State Department of Social Services
Biddle Building, 1st Floor
2700 West 6th
Topeka, Kansas 66606

KENTUCKY
Department for Human Resources
Division for Aging Services
Alternate Care Branch
275 E. Maine Street, 6th Floor W.
Frankfort, Kentucky 40601

LOUISIANA
Division of Evaluation and Services
P.O. Box 3318
Baton Rouge, Louisiana 70821

MAINE
Adult Protective Services
Department of Human Services Bureau
of Resources Development, Station 11
State House
Augusta, Maine 04333

MARYLAND
State Social Services Administration
Adult Protective Services
11 South Street
Baltimore, Maryland 21212

MASSACHUSETTS
Department of Social Services
11th Floor
150 Causeway Street
Boston, Massachusetts 02114

MICHIGAN
Office of Adult and Family
Community Services
Adult Protective Services Division
300 South Capitol Avenue
P.O. Box 30037, Suite 707
Commerce Center Building
Lansing, Michigan 48910

MINNESOTA
State of Minnesota
Department of Public Welfare
Centennial Office Building
St. Paul, Minnesota 55155

MISSISSIPPI
Department of Public Welfare
Jackson, Mississippi

MISSOURI
Missouri Division of Aging
P.O. Box 570
Broadway Office Building
Jefferson City, Missouri 65102

MONTANA
Dept. of Social and Rehabilitative
Services
Social Services Division
Box 4210
Helena, Montana 59601

NEBRASKA
Division of Social Services
Adult Service Unit
Nebraska Department of Public
Welfare
Lincoln, Nebraska 68509

NEVADA
Nevada State Welfare Division
251 Jeanell Drive
Carson City, Nevada 89710

NEW HAMPSHIRE
Division of Welfare
Bureau of Adult Services
Haven Drive
Concord, New Hampshire

NEW JERSEY
Dept. of Human Services
Div. of Youth and Family Services
Trenton, New Jersey 08625

NEW MEXICO
Field Services Bureau
Social Services Division
Human Services Department
P.O. Box 2348
Santa Fe, New Mexico 87503

NEW YORK
New York State Dept. of Social
Services
Aging Services Section
40 North Pearl St.
Albany, New York 12243

NORTH CAROLINA
North Carolina Division of Social
Services
325 North Salisbury Street
Raleigh, North Carolina 27611

NORTH DAKOTA
County Social Service Boards

OHIO
Bureau of Adult Services
Ohio Department of Public Welfare
30 East Broad Street
Columbus, Ohio 43215

OKLAHOMA
Department of Human Services
Division of Services to Adults and Families
P.O. Box 25352
Oklahoma City, Oklahoma 73125

OREGON
Adult and Family Services
Department of Human Resources
400 Publis Services Building
Salem, Oregon

PENNSYLVANIA
Department of Public Welfare
Room 533
Health and Welfare Building
Harrisburg, Pennsylvania 17120

RHODE ISLAND
Family and Adult Services
600 New London Avenue
Cranston, Rhode Island 02920

SOUTH CAROLINA
Adult Services Division
Adult Protective Services Unit
State Department of Social Services
Box 1520
Columbia, South Carolina 29202

SOUTH DAKOTA
Office of Adult Services
Kneip Building, Illinois Street
Pierre, South Dakota 57501

TENNESSEE
Tennessee Department of Human Services
Division of Social Services
Protective Services for Adults
111-19 7th Avenue North
Nashville, Tennessee 37203

TEXAS
Alternate Care for Aged and Disabled
Adults Division
Texas Department of Human Resources
P.O. Box 2960
Austin, Texas 78769

UTAH
State Division of Aging
150 West North Temple #326
P.O. Box 2500
Salt Lake City, Utah 84103

VERMONT
Department of Health
60 Main Street
Burlington, Vermont 05401

VIRGINIA
Virginia State Department of Welfare
8007 Discovery Drive
Richmond, Virginia 23288

WASHINGTON
Bureau of Aging
OB-43G
Olympia, Washington 98504

WEST VIRGINIA
All Welfare Department Area Offices

WISCONSIN
Adult Service Units in 72 counties

WYOMING
Wyoming Department of Health and
Social Services
Division of Public Assistance and
Social Services
Hathaway Building
Cheyenne, Wyoming 82002

○